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HEALTH PLANNING

BUREAU OF HEALTH MAINTENANCE ORGANIZATIONS AND RESOURCES DEVELOPMENT

WESTERN CONSORTIUM/WESTERN CENTER FOR HEALTH PLANNING

Guide to Health Planning Law

A Topical Digest of Health Planning and Certificate of Need Case Law

Third Edition

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U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration

WESTERN CONSORTIUM/WESTERN CENTER FOR HEALTH PLANNING

Guide to Health Planning Law

A Topical Digest of Health Planning and Certificate of Need Case Law

Third Edition

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HEALTH & HUMAN SERVICES
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SECTION ONE: HOW TO USE THE GUIDE TO HEALTH PLANNING LAW

I. Introduction

The Guide to Health Planning Law is a service of the Legal Resources Program at the Western Center for Health Planning. The Legal Resources Program is a federally-funded project providing technical legal assistance to local and state health planning agencies nationwide.

The Guide to Health Planning Law is a specialized research tool for lawyers, health planners, and others who must work within the complex regulatory system created by the National Health Planning and Resources Development Act (NHPRDA) and the various state Certificate-of-Need statutes. Although its subject-matter is judicial decisions, the authors intend that it be a useful reference tool for non-lawyers, and it has been prepared and organized with that end in mind.

The Guide contains two major sections: an introductory text describing certificate of need and health planning law and a topical digest of certificate of need and health planning case law. The topical digest consists of a detailed table of contents in outline form listing the topics and issues which arise in health planning, followed by detailed annotations to the judicial opinions that have considered those topics and issues.

The Legal Resources Program is uniquely positioned to produce the Guide because of its status as a national legal technical assistance center to the local and state health planning agencies. At the behest of the Office of Health Planning in the U.S. Department of Health and Human Services, federally-funded health planning agencies are required to send a copy of the complaint, major filings, and any judicial decisions rendered in all litigation involving the agency to the Legal Resources Program. Because of this unique reporting network, the Legal Resources Program has access to comprehensive, current information about the state of the law in health planning.

Additional services of the Legal Resources Program.

A copy of the Guide is made available at or below cost to federally-funded health planning agencies nationwide. The LRP also periodically distributes other technical assistance materials to its agency clientele, appears at meetings and conferences sponsored by the Western Center for Health Planning, and provides consultative services to individual agency staff and attorneys.

The Legal Resources Program does not provide technical assistance to its non-health planning agency subscribers to the Guide. However, the following services are available to all agency and non-agency subscribers:

- o Copies of all judicial opinions reported in the Guide and the Legal Briefing Memo. Twenty-five (25¢) cents per page. Call Legal Resources Program Secretary Denise Nilsson: (415)546-7601.

II. Legal Briefing Memo: Case Update Service for the Guide

New judicial opinions in cases concerning health planning and certificate of need appear frequently. It is necessary to maintain the currency of your Guide by incorporating these new decisions.

The Legal Resources Program periodically distributes a newsletter to its planning agency clientele, entitled the Legal Briefing Memo. Guide purchasers receive an initial one-year subscription to the Legal Briefing Memo. The Legal Briefing Memo is a case update service containing descriptions, in the Guide format, of new judicial decisions in health planning and certificate of need.

When you purchase your Guide, you may find one or more Legal Briefing Memos bound into the back of the text, depending on the date on which you purchased the Guide. In order to be able to research an issue or topic by beginning with the Guide and using the Briefing Memos as a supplement, you must hand enter into your Guide appropriate cross-references to cases reported in the Legal Briefing Memos which are bound into the back of your Guide and reported in the subsequent Briefing Memos you receive by mail, in accordance with the updating procedure described below. We expect to print a fully revised fourth edition of the Guide, incorporating the case annotations contained in Briefing Memos 46 through 53, in mid-1986. Cases originally reported in Legal Briefing Memos 1 through 45 are incorporated into the text of this third edition of the Guide.

III. How to Update the Guide

The Guide is updated through the Legal Briefing Memo newsletter.

Update Categories

The Briefing Memo contains sections which report on New Decisions, Previously-reported Decisions, and Current Litigation. The New Decisions section reports on judicial opinions in cases involving health planning and certificate of need/1122 which are not annotated in the main text of the Guide, including cases noted in the Current Litigation section of previous Briefing Memos. Previously-reported Decisions reports on judicial opinions, such as appellate court decisions, in cases already annotated in the Guide or reported in the New Decisions section of earlier Briefing Memos. Current Litigation briefly describes pending cases raising interesting or novel issues.

Update Procedure

At the end of each case description in the New Decisions and Previously Reported Decisions sections of the Legal Briefing Memo is the phrase "UPDATE THE GUIDE AT:" followed by one or more Guide references. These update references, consisting of an outline section number and heading name, and a Topical Digest page number, will enable a Briefing Memo reader possessing a copy of the Guide to refer back from the Briefing Memo to the cases annotated in the Guide which deal with the same topics as the new decision reported in the Memo.

Promptly following receipt of each Briefing Memo, we suggest that you make a notation in the margin of the page(s) of your Guide indicated in the update references in the Briefing Memo. You will need to do this for each Briefing Memo you receive. The notation should contain the number of the issue of the Legal Briefing Memo series in which the update material appears, the case name, and, if you wish, a citation, etc.

You will observe that each update reference in the Legal Briefing Memo contains two page numbers, e.g., [p. 110, (3d ed. 115)]. This is because at certain times there are two differently paginated editions of the GUIDE in circulation, the third edition (which you have) and either the older second edition or the newer fourth edition. The second of the two page numbers in each update reference refers either to the third or fourth edition page, as indicated. The first number refers to whichever earlier edition is still in circulation (i.e., the second or third edition).

If you make the proper notations, it will be possible for you to research an issue or topic by beginning with the Guide and using the Briefing Memos as a supplement. Occasionally, a decision reported in the Briefing Memo will deal with a new subject or topic not listed in the Guide's Topical Digest outline. When that occurs, the update reference following the case description in the Briefing Memo will list a new outline section number and a new heading. We recommend that you note the new section number and heading in your Guide at the appropriate location in the detailed outline of the Topical Digest (the tan pages) and on the proper page of the Digest itself.

Saving Briefing Memos

Since the Briefing Memo or a part of it will update the Guide, we suggest that you keep Briefing Memos with the Guide.

IV. Researching Issues and Topics

Readers of the Guide are likely to fall into one of two groups: those seeking an introduction to health planning law or general information about a specific topic in health planning and certificate of need on the one hand, and on the other hand those readers, typically persons with some prior experience in health planning law and often lawyers, who are researching a specific question or issue.

Readers seeking general or introductory information are advised to begin by examining SECTION TWO: INTRODUCTION TO HEALTH PLANNING AND CERTIFICATE OF NEED. The text in Section Two will often be sufficient to answer general questions or to enable a reader to focus in on topics of particular interest which can then be more thoroughly researched in the manner described below.

Readers interested in researching specific topics should consult the detailed outline of contents of the topical digest to find the topics in which they are interested. They can then turn to the pages in the Guide where the judicial decisions on those topics are discussed in detail.

Researching With the Guide

As lawyers know, the best source of authoritative interpretation and analysis of a state's health planning and certificate of need law and regulations is the judicial opinions of the courts of that state and, within a state, the opinions of the highest appellate court. When a particular issue in health planning law has been addressed by courts of your state and other states, you should focus your attention on the decisions from your state, and within your state, on the decisions of the highest court.

Unfortunately, in health planning and certificate of need law you will seldom have the luxury of a judicial decision on a particular issue from the courts of your state. In these circumstances you must turn to the courts of other states for guidance. This fact is, of course, the raison d'etre for the Guide to Health Planning Law. Judicial opinions from other states are often not familiar to practitioners in a given state. The commercial firms which publish digests of officially reported judicial opinions from other states do not distinguish among the many specialized issues in health planning and certificate of need law. Unreported judicial opinions from one's own and other states are typically unknown to all but a few specialists.

Nevertheless, the interpretations, holdings, and analyses contained in such opinions can be extremely valuable. As SECTION TWO explains in greater detail, there are substantial similiarities among all state certificate of need laws, as a consequence of the highly prescriptive requirements of the federal Health Planning Act. Because of this fact legal interpretations of one state's CON statutes will be highly persuasive, though not controlling, authority in other states. In addition, interpretations from other states are useful in predicting how courts and administrators in one's own state will interpret the law, and in assisting in making one's own legal analysis. Bear in mind too, that it is important to learn that there have not been any judicial decisons on a particular issue in the state in which you are located.

Furthermore, there are issues in health planning law involving the interpretation of the federal Health Planning Act and other federal statutes. A good example would be the cases involving the issue of implied repeal of the federal antitrust laws by the NHPRDA. The judicial opinions in these cases are relevant and important no matter what state you are in.

In summary, the body of law reflected in the judicial opinions discussed in the Guide represents a major resource for interpreting your state health planning and certificate of need law.

Reading the Case Abstracts

The topical digest consists of several hundred individual case abstracts, organized by topic. Within a given topic, there may be several cases, and since there are often several holdings or rulings in a judicial opinion, a case may appear in several locations in the topical digest.

Each case abstract is organized, as much as possible, in a standard format. First, the case name and legal citation are given. Citations follow the form of the Uniform System of Citation, except that parallel citations to state reporters are usually omitted. Unreported opinions are cited by case or docket number, court, and date of decision.

The case discussions begin with a one or two sentence summary of procedural setting of the case and the basic elements of the controversy. Next the relevant facts are set forth. Following that the court's holding or ruling is described and the reasons for the holding set forth. Multiple holdings or reasons may be numbered for convenience. In general the abstracts do not quote from the judicial opinions. However, the descriptions of the reasons for the courts' holdings often paraphrase or use portions of the courts' opinions.

We have attempted to include in the case abstracts every holding in the opinions which is relevant to certificate of need and health planning. Excluded are holdings on matters, such as issues of local procedure, of no unique significance to CON and health planning and no interest to persons outside the state, and holdings for which no reasons are given or can be discerned.

The case abstracts are "neutral" in the sense that we attempt to report accurately the substance of the Court's decision and its reasons, whether we find them persuasive or not. Editorial comments are contained in the introductory textual notes or within brackets.

What Else Do You Need Besides The Guide?

You should have a current copy of your state health planning and certificate of need statute and any administrative regulations, interpretive guidelines, etc. You should also have access to a copy of NHPRDA, and the federal regulations. NHPRDA is codified at 42 U.S.C. §§300k et seq. The current federal regulations relating to NHPRDA are contained in 42 CFR Parts 121-23. Recently amended federal CON regulations may be found at 50 Fed.Reg. 2008 et seq. (Jan. 14, 1985). Current copies of your state's CON statute and regulations are available from your State Health Planning and Development Agency or a law library in your state (not all law libraries will have copies of health planning regulations). NHPRDA and its regulations are available at law libraries. If you are doing extensive legal research or preparing briefs, legal memoranda, etc., you may wish to obtain copies of the judicial opinions annotated in the Guide. The citations to officially-reported decisions accompany the annotations in the topical digest. Using the citations you can find the opinions in the case reporters at a law library. If you do not have ready access to a law library, you may obtain copies of the opinions from the Legal Resources Program.

Copies of unreported judicial opinions annotated in the Guide may be obtained from the Clerk of the Court which decided the case or from the Legal Resources Program. The citations to unreported judicial opinions given in the Guide are designed to provide sufficient information to enable the reader to identify the court of decision and to identify the case to the Court Clerk. However, it will usually be possible to obtain an opinion more quickly, and often at a lower price, by calling the Legal Resources Program.

A final reminder: The purpose of the Guide to Health Planning Law is to provide information not available elsewhere about legal issues unique to health planning and certificate of need. It is important, however, to recognize that many of the legal issues arising in health planning law also arise in other factual contexts.

For example, the requirement of exhaustion of administrative remedies as a prerequisite to judicial review is a general rule of administrative law not unique to health planning. Therefore, when you are doing legal research in connection with a controversy involving health planning agencies, you should also be looking for precedents and guides on the issues in question from outside the field of health planning law as well as within the field. Many of the disputed issues in health planning law involving general rules or principles of law will arise in the field of administrative procedure and judicial review of administrative action. Therefore, a good general research source will be West's Topical Digests: Administrative Law or a similar legal digest.

V. Definitions of Legal and Technical Terminology in the Guide

Throughout the Guide you will find the use of technical and legal terms whose meaning may be unfamiliar to you. The authors have sought to minimize the use of legal jargon. However, it is necessary from time to time to use specialized legal terminology. Brief definitions of some of the technical terms are provided below. For additional information, the authors suggest that you consult Black's Law Dictionary (4th ed. 1968) and/or DAVIS, ADMINISTRATIVE LAW TEXT both of which are available at law libraries.

Administrative Procedures Act

The federal government, and virtually every state, have adopted laws setting forth the rules governing the practices and procedures of their administrative agencies, particularly as they relate to rule-making and adjudication. These laws are typically codified together and denominated the (State) Administrative Procedures Act.

Defendant

The party against whom relief or recovery is sought in a legal action. The party bringing the action is denominated the plaintiff. The plaintiff's name is listed first in a case name; thus in Jones v. Smith Jones is the plaintiff, Smith the defendant. In actions brought to review administrative decisions the plaintiff may be labeled the petitioner and the defendant the respondent. When the decision of a trial court is appealed the parties can be redesignated as the appellant--the party bringing the appeal--and the appellee--the party against whom the appeal is brought. In GUIDE annotations the parties are identified either by name or as the plaintiff and the defendant.

Exhaustion of Administrative Remedies

A legal doctrine or principle providing that where an administrative remedy, such as an appeal to a higher administrative decision-maker, is provided by statute, a person seeking relief from an initial administrative decision must pursue the administrative remedy before he can seek redress in the courts.

Grandfather Clause

A statutory exemption from a regulatory scheme, such as certificate of need review, for businesses or projects already established on the date the regulatory scheme becomes effective.

Ex parte Contacts

Contacts or communications with the official decision-maker done by or on behalf of one of two or more parties to an official proceeding which are off the record or out of the presence of the other party.

Standing

A set of legal doctrines, based on constitutional, statutory, and common law grounds, which permits only those persons who have a significant, personal stake in the outcome of a controversy to bring legal actions to resolve the controversy. The standing-related cases reported in the GUIDE tend to fall into one of two categories: (1) cases raising the question whether a class of persons is granted the right by statute to obtain administrative or judicial review of an administrative agency decision in CON or 1122; and (2) whether a particular individual falls within a class of persons granted such right. The GUIDE annotates the first category of cases under the headings "Availability of relief by way of administrative appeal" or "Availability of relief by way of judicial review." It annotates the second category of cases under the headings "Standing to obtain administrative appeal" or "Standing to obtain judicial review."

Estoppel

A legal doctrine or principle providing that under certain circumstances a person may be barred from alleging or denying a fact because of his previous denial or allegation of the same fact.

Remand

Literally, "sending back." The process by which a court reviewing the decision of an inferior tribunal (a lower court or an administrative agency) sends the case back down for additional proceedings, often with special directions to the lower decision-maker on how to proceed. Remand is the typical remedy on judicial review and overturning of a CON decison where there remain after the Court's decision issues to be decided in the discretion of the agency. Since the Court cannot decide discretionary issues without usurping the agency's authority the Court must remand to the agency.

Holding

In a judicial opinion, a conclusion on a legal issue by the judge which is necessary to resolve the controversy being litigated. Conclusions or statements in an opinion which are not necessary to the resolution of the case are called dicta. Technically, they do not form the law of the case and do not have binding precedential value.

VI. List of Abbreviations Frequently Used

AG - Attorney-General
APA - Administrative Procedure Act
AR - Appropriateness Review
CHP - Comprehensive Health Planning. The term is used to refer to P.L. 89-749, the Comprehensive Health Planning Amendments of 1966 and to the local, regional, and state health planning agencies established by that law.
CON - Certificate of Need
CT - Computerized Tomography
DPA - Designated Planning Agency, the state agency designated to review capital expenditures under the Section 1122 program
HHS & Departments of Health and Human Services and
HEW - Health, Education, and Welfare, its predecessor
HSA - Health Systems Agency
HUD - Department of Housing and Urban Development
ICF - Intermediate Care Facility
LTC - Long-term Care
NEPA - National Environmental Policy Act of 1969
NHPRDA - National Health Planning and Resources Development Act
NMR - Nuclear Magnetic Resonance
NOI - Notice of Intent
PRRB - Provider Reimbursement Review Board
PUFF - Proposed Uses of Federal Funds
SHCC - Statewide Health Coordinating Council
SHPDA - State Health Planning and Development Agency
SNF - Skilled Nursing Facility

SECTION TWO: INTRODUCTION TO HEALTH PLANNING AND CERTIFICATE OF NEED

I. HISTORY OF HEALTH PLANNING IN THE UNITED STATES

Though health planning does not have a long history in the United States, it has gone through several stages and has involved at least half a dozen different governmental programs at various times. The organizational setting for health planning has also varied over time and from place to place, including both private organizations and governmental agencies at the state, regional and local level. The discussion in this section will briefly describe the programs and organizations which preceded the current health planning scheme.

Early Non-Governmental Planning Efforts

The first stage of health planning had its origins in the 1930s with joint health and welfare fund-raising groups which solicited and then allocated local charitable contributions. Planning to determine community priorities was a necessary adjunct of this process. In the 1940s, when hospitals began to look to charity for the substantial funds they needed for capital expansion after more than a decade of depression and war, the large contributors began to create separate specialized planning organizations to allocate capital among hospitals in a manner that made the most effective use of the charitable funds.[1] Thus independent hospital councils developed in cities such as New York, Detroit, and Pittsburgh. By 1964 there were councils in 33 metropolitan areas.[2]

By the early 1960s, many of these areawide agencies had broadened their scope beyond "bricks and mortar" construction to include concerns about hospital operating expenses, organizational and financing issues, and non-acute and non-institutional services. Also, they were no longer exclusively controlled by corporate contributors. Health professionals, local government, Blue Cross, insurance companies, banks, and the hospitals themselves were represented on their governing boards or exerted some influence in their decision-making processes.[3]

The Hill-Burton Program

The federal government's involvement in health facilities planning began in 1946 with the passage of the Hospital Survey and Construction Act, popularly known as the Hill-Burton Act, which provided federal grants for hospital construction.[4] The Act required states for the first time to develop a formal health facilities planning process. Each participating state submitted a state plan which designated a single state Hill-Burton agency and a state advisory council. The plan also included a statewide survey of need, plans for sub-state areas, and an inventory of existing facilities. The plan set forth the number of facilities of various kinds, including hospital inpatient beds, needed in the state and how they should be geographically distributed throughout the state. The state plan also included a construction (and later modernization) program for meeting the needs identified in the survey "in order of relative need" among different types of facilities.[5] Applications by hospitals for federal Hill-Burton funds had to conform to the state plan and be approved by the state Hill-Burton agency before they could receive federal approval.[6]

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[1] *S. Gottlieb, "A Brief History of Health Planning in the United States," in Regulating Health Facilities Construction 7,11-12 (edited by C. Havighurst, 1974).*

[2] *Id. at 12.*

[3] *Id. at 13.*

[4] *P.L. 79-725 (codified at 42 U.S.C. §291 et seq.).*

Both the Community Health Services and Facilities Act of 1961[7] and the Hospital and Medical Facilities Amendments of 1964[8] authorized grants from Hill-Burton funds to local health planning agencies, popularly known as "section 318" agencies (for the Public Health Service Act section which contained the authority). These federal grants stimulated the development of many new local agencies during the early Sixties: the number of agencies increased from 14 in 1961 to 80 in 1966.[9] The Medical Facilities Construction and Modernization Amendments of 1970[10] for the first time required state agencies to give local planning agencies (by that time "Comprehensive Health Planning" agencies, discussed below) an opportunity to consider applications for Hill-Burton funds.[11]

Regional Medical Programs

In 1965 Regional Medical Programs (RMPs) were established as the planning and coordinating component of a federal program aimed at combating heart disease, cancer, and stroke.[12] In 1970 statutory amendments increased the RMP program's emphasis on primary care and its linkage to regionalized tertiary services and on health manpower in underserved areas.[13] Consequently, in their later years the approximately 60 local RMPs increased their emphasis on community involvement and a more comprehensive range of service delivery needs, such as emergency medical services and primary care in underserved areas. RMPs thus began to resemble Comprehensive Health Planning agencies.[14] However, RMPs were never linked to any regulatory or reimbursement programs.

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[5] *42 U.S.C. §291d.*

[6] *42 U.S.C. §291e(b)(3)-(4).*

[7] *P.L. 87-395.*

[8] *P.L. 88-443.*

[9] *J. May, Health Planning: Its Past and Potential 40 (1967).*

[10] *P.L. 91-296, §111(a).*

[11] *42 U.S.C. §291e(b)(4).*

[12] *Heart Disease, Cancer, and Stroke Amendments of 1965, P.L. 89-239, §2 (codified at 42 U.S.C. §§299-299e).*

Comprehensive Health Planning

In the Comprehensive Health Planning and Public Health Services Amendments of 1966,[15] Congress authorized funds to assist both state and areawide (local) health planning agencies. State agencies, which would come to be known as "a" agencies (because their funding was authorized by Section 314(a) of the Public Health Service Act), had to submit a state plan in order to receive federal funds. The plan had to designate a single state agency to perform comprehensive health planning and had to establish an advisory state health planning council broadly representative of public and private health organizations with a consumer majority. The state agency was to consider the public and private facilities, services, and personnel required to meet the health needs of the population and encourage "cooperative efforts" among health, education, welfare, and rehabilitation providers and agencies.[16] Areawide health planning agencies (called "b" agencies, because they were authorized by section 314(b) of the PHS Act) would, with the approval of the "a" agency, receive funds to expand the health facilities planning done by the Hill-Burton-funded 318 agencies to include all health services and manpower. Local agencies were to develop "comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned services."[17] Beyond requiring them to be public or non-profit agencies, the 1966 law said nothing about how "b" agencies would be organized or governed or who would sponsor them.

The Partnership for Health Amendments of 1967[18] required the state agency to assist health care facilities in developing institutional capital expenditures programs and periodically review and recommend modifications to such programs.[19] The legislative history expressed

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[13] Public Health Service Act Amendments of 1970, P.L. 91-515.

[14] U.S. House of Representatives, Report No. 93-1382, 93d Congress, 2d Session 20 (1974).

[15] P.L. 89-749 (codified at 42 U.S.C. §246).

[16] 42 U.S.C. §246(a)(2).

[17] Id. §246(b)(1)(A).

[18] P.L. 90-174.

[19] 42 U.S.C. §246(a)(2)(I).

the hope that such assistance would result in elimination of duplicative services and the intention that it not be used to "control" institutional planning.[20]

The CHP legislation was amended twice in 1970. In the Medical Facilities Construction and Modernization Amendments of 1970, "b" agencies were required to provide means for representation of hospitals and other health care facilities, practicing physicians, and the general public.[21] These amendments also required that "b" agencies have an opportunity to review applications by facilities for Hill-Burton assistance before the state Hill-Burton agency acted on them.[22]

The Public Health Service Amendments of 1970[23] also made some significant changes to the CHP law. A National Advisory Council on Comprehensive Health Planning Programs was established to advise the Secretary of DHEW.[24] Local agencies were required to establish areawide health planning councils which represented public and private health organizations, local government, RMP, and consumers. Consumers were required to be in the majority.[25] The "a" agency requirement to assist facilities with their capital expenditure programs was extended to "b" agencies.[26]

In the Social Security Amendments of 1972, a federal statute for the first time linked "a" and "b" agencies to reimbursement and regulation of health care facilities through the "Section 1122" program (described below). Also, in the more than twenty states which enacted Certificate of Need statutes in the late Sixties and early Seventies (see below), CHP was linked to CON. State agencies were often instrumental in securing passage of state CON laws, under which they sometimes were given CON authority, while "b" agencies generally performed local review of CON applications.[27] During the same period, support for planning from business and insurers was reflected in Blue Cross agreements with hospitals requiring planning agency review of capital projects as a prerequisite to Blue Cross reimbursement.[28] In the later years of the program (after 1972), DHEW began to increase its emphasis on CHP activities intended to contain costs and estimate resource requirements.

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[20] U.S. Senate, Report No. 724, 90th Congress, 1st session (1967 U.S. Code, Congressional and Administrative News 2076, 2078).

[21] P.L. 91-296, §111(b)(codified at 42 U.S.C. §246(b), now §246(b)(1)(A)).

[22] Id. §111(a) (codified at 42 U.S.C. §291e(b)(4)).

[23] P.L. 91-515.

[24] Id. §281 (codified at 42 U.S.C. §247a).

[25] Id. §230 (codified at 42 U.S.C. §246(b)(2)(A)).

[26] Id. (codified at 42 U.S.C. §246(b)(2)(B)).

[27] U.S. Senate, Report No. 93-1285, 93d Congress, 2d Session 9-11 (1974 U.S. Code, Congressional and Administrative News 7842, 7850-52).

By the mid-Seventies both Congress and other CHP participants and observers had identified a number of weaknesses and problems in the program. Funding (and staffing) had never begun to match expectations. In its eight-year history a total of only 178 million dollars had been appropriated for CHP, while hundreds of billions of dollars were spent on health services.[29] Local CHP agencies had devoted most of their limited resources for their first several years to efforts to establish effective organizational structures. The program had ambiguous, conflicting, constantly changing goals. Until the Section 1122 and CON programs were initiated, agencies had little legal authority to implement their plans, and providers had failed to comply voluntarily. Technical methodologies, criteria, and procedures were not well developed. Compounding all these problems was the reliance by "b" agencies on local providers for matching funds, making objective review and evaluation of those providers impossible.[30]

State Certificate of Need Laws

While Comprehensive Health Planning was developing primarily as a voluntary activity during the Sixties, political forces were leading to the passage of Certificate of Need (CON) laws in a number of states. CON was supported by those who advocated "planning with teeth," so that health planning agencies could implement those parts of their plans which sought to constrain health facility construction. In 1964 New York became the first state to enact CON, followed by Rhode Island and Maryland in 1968, and California and Connecticut in 1969. The pace accelerated in the early Seventies: eleven states passed CON laws in 1971; five in 1972; three in 1973; and three in 1974.[31]

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641, discussed in detail below) conditioned receipt of federal health grant money on development by states of CON programs which met minimum requirements. As a result, 29 additional states and territories passed CON legislation after 1974. In addition, many states have operated "Section 1122" programs (discussed below). In mid-1984, every state had either a CON program, an 1122 program, or both. Louisiana, New Mexico, and Idaho had 1122 only; the rest had either CON alone or both programs. However, extensive changes were brewing. Spurred by impatience with Congressional delay in reauthorizing NHPRDA funding (see text accompanying Note 47 infra) and interest in non-regulatory solutions to health care cost containment, by mid-1985, five states had repealed CON. Three of these, Arizona, Texas, and Utah did not adopt any substitute mechanism for controlling capital investment by health facilities. The other two, Minnesota and Kansas, adopted two-year moratoria on new health facility construction and addition of beds.

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[28] *National Academy of Sciences, Institute of Medicine, Health Planning in the United States: Issues in Guideline Development 15 (1980).*

[29] *Senate Report No. 93-1285, supra note 27, at 8 (U.S.C.C.A.N. 7849).*

[30] *J. Blumstein & F. Sloan, "Health Planning and Regulation Through Certificate of Need: An Overview," 1978 Utah Law Review 3, 8; K. Wing, The Law and the Public's Health 134-35 (1976).*

[31] *Chayet & Sonnenreich, P.C., Certificate of Need: An Expanding Regulatory Concept 5-6 (1978).*

II. CURRENT HEALTH PLANNING LAWS

This section will provide an overview of the three current sources of legal authority for health planning - Section 1122 of the Social Security Act, the National Health Planning and Resources Development Act (Titles XV and XVI of the Public Health Service Act), and state Certificate of Need laws. A brief review of the legislative history of Section 1122 and P.L. 93-641 and subsequent amendments is followed by a description of those provisions of Title XV which do not relate directly to CON. The final section will explain the complicated interaction among Title XV and state CON laws and 1122 programs.

Section 1122

Section 1122 was added to the Social Security Act by the Social Security Amendments of 1972,[32] a massive piece of legislation which made a number of amendments to the Medicare and Medicaid programs designed to reduce rapid cost increases.[33] Section 1122 is a federal capital expenditure review program, similar in most respects to CON, under which the federal government contracts with and pays states "willing and able" to conduct reviews according to federal requirements. The expressed purpose of the 1122 program was to assure that the Medicare and Medicaid programs were not working at cross-purposes with federally-supported Comprehensive Health Planning by paying for capital projects which were inconsistent with plans developed by state and local CHP agencies.[34] Legislation to link Medicare and Medicaid reimbursement with CHP plans had first been introduced in 1967.[35]

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[32] P.L. 92-603, §221(a)(codified at 42 U.S.C. §1320a-1).

[33] See, e.g., P.L. 92-603, §223 (codified at 42 U.S.C. §1395x(v)(1)(A)); Id. §249F(b) (the Professional Standards Review Organization program, codified at 42 U.S.C. §1320c et seq.).

[34] U.S. House of Representatives, Report No. 92-231, 92d Congress, 2d Session (1972 U.S. Code, Congressional and Administrative News 4989, 5065-66).

[35] Chayet & Sonnenreich, supra note 31, at 12.

Under Section 1122, capital expenditures which exceed $600,000 or which change bed capacity or services are subject to review. The federal statute and regulations specify review procedures and criteria, based on the state and local health planning system, to be used by the state "Designated Planning Agency" or DPA. The state must provide an opportunity for a "fair hearing" concerning DPA decisions by an independent hearing officer, and judicial review by state courts may also be available. A final determination based on the state decision is made by the federal government. If the proposed capital expenditure is disapproved, then Medicare and Medicaid reimbursement for the capital costs of the project will be denied. However, in contrast to CON, the applicant is not legally prohibited from proceeding with the project. Section 1122 is administered by the federal Office of Health Planning, which also administers the National Health Planning and Resources Development Act.

Most states entered into 1122 contracts within two years of passage of the 1972 law. In 1973 and 1974, 40 states, 16 of which already had CON laws, began doing 1122 review. By 1975 every state except West Virginia and the District of Columbia had a CON law or an 1122 program or both.[36] Thus, with very few exceptions, the states which passed CON statutes after P.L. 93-641 already had 1122 programs. Some states ended their 1122 program after adopting CON, but many states continued to operate 1122 and CON concurrently, with a single review process but two sets of sanctions.

As part of a major restructuring of the Medicare reimbursement principles, in 1983 Congress adopted an important provision relating to Section 1122. It provided that if by October 1, 1986 a mechanism for incorporating the costs of capital into the new Medicare "prospective payment system" had not been enacted, states would be effectively required to enter into 1122 agreements with DHHS. [36.5] As of mid-1985 no such mechanism had been adopted.

The National Health Planning and Resources Development Act of 1974

In 1973 Congress decided to extend authorizations for Comprehensive Health Planning, Regional Medical Programs, and the Hill-Burton program (and other Public Health Service programs) for one year with the understanding that in 1974 an in-depth review of the programs and whether and in what form they should be continued would be conducted. This study, combined with a deepening concern about the need for mechanisms to control health care costs, especially costs related to excess hospital capacity, led to the formulation and enactment of the National Health Planning and Resources Development Act of 1974.[37]

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[36] Chayet & Sonnenreich, *supra* note 31, at 5-6.

[36.5] *See* 42 U.S.C. §1395ww(g)(1) (Supp. VII 1983)

[37] P.L. 93-641 (codified at 42 U.S.C. §§300k to 300t-14).

The Act added two new titles to the Public Health Service Act. Title XV contained the health planning provisions (described in detail below). Title XVI, the "Resources Development" part of the Act, was designed to supplant the pre-existing Hill-Burton program (though the old Hill-Burton provisions have never been repealed).[38] With the exception of grants authorized by section 1625 to public hospitals for projects to prevent imminent safety hazards and correct licensure and local code deficiencies, Congress has never appropriated any money for Title XVI construction and modernization projects. Nor did it appropriate money for "area health services development funds" authorized by section 1640, from which Health Systems Agencies were to make planning grants to local health resources projects which they determined were needed.[39] Finally, no funds were appropriated for provisions added to Title XVI in 1979, which authorized grants to hospitals and state health planning agencies for voluntary discontinuance and conversion of excess hospital capacity.[40] Thus Title XVI has never had any significant impact on health planning or resources development.

Title XV established a substantially re-organized three-tiered federal- state-local health planning system for the United States. The law authorizes federal funds for state and local health planning agencies which meet minimum federal standards; it does not by itself create an enforceable federal or state regulatory or planning program. When P.L. 93-641 was passed, the authorizations for RMP and CHP were allowed to lapse, although as with Hill-Burton the underlying statutory provisions were not repealed. It is often helpful to remember, in trying to understand and interpret the provisions of Title XV, that, far from developing a health planning program in a vacuum, the drafters of the law were responding to perceived problems in these pre-existing programs.

Four main themes seem to have received the most emphasis in the language and legislative history of P.L. 93-641: the need for regulatory "teeth" to enforce health planning decisions, especially those aimed at controlling costs (hence the CON requirements); a need for more detailed plans, criteria, and methodologies on which to base such decisions; the need for more skilled professional staff; and the belief that planning must be controlled by or accountable to consumers, albeit with substantial provider participation.[41]

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[38] *Codified at 42 U.S.C. §§300q to 300t-14.*

[39] *§1513(c)(3) [§300l-2(c)(3)]. Hereinafter, all citations to Title XV will contain only the section number of the Public Health Service Act, followed by the parallel section number of 42 U.S.C.*

[40] *§§1641-1644 [§§300t-11 to 300t-14].*

[41] *For the complete legislative history of P.L. 93-641, see House Report No. 93-1382, supra note 14; Senate Report No. 93-1285, supra note 27; U.S. House of Representatives, Report No. 93-1640, 93d Congress, 2d Session (conference report; 1974 U.S. Code, Congressional and Administrative News 7971).*

Title XV has been amended several times by Congress. The 1979 amendments[42], which affected nearly every provision in Title XV, are by far the most important. The 1981 amendments[43] also made some important changes. Relatively minor amendments were adopted in 1980.[44] Several of these amendments will be discussed in detail below.

Title XV Provisions Not Concerning Certificate of Need

Since most of the provisions of Title XV do not involve any kind of regulatory activity which has a binding effect on health care providers, they have not raised major legal issues or resulted in litigation. For this reason, these parts of the law will be treated briefly, even though they may have been important and even controversial in the federal administration of the program. Those sections which have been the subject of litigation are noted.

In the discussion that follows, sections of Title XV of the Public Health Service Act will be described. Following the Title XV section numbers (between 1501 and 1536) the parallel section numbers in Title 42 of the U.S. Code (between 300k and 300n-5) appear. Thus "section 1501(300k-1)" refers to section 1501 of the PHS Act, which is codified at 42 U.S.C. §300k-1. A few minor sections of Title XV have been omitted. For most of these sections, administrative regulations have been promulgated under the authority of Title XV by the Office of Health Planning (OHP), Health Resources and Services Administration (HSA), Public Health Service (PHS), Department of Health and Human Services (DHHS, formerly the Department of Health, Education, and Welfare, DHEW), which administers both the health planning and 1122 programs. All these regulations appear in parts 121-123 of Title 42 of the Code of Federal Regulations.

Section two of P.L. 93-641 (not in Title XV; 300k) contains Congressional findings, the most important being that "the achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government." Section 1501 (300k-1) requires DHHS to issue guidelines with "standards respecting the appropriate supply, distribution, and organization of health resources" and "a statement of national health planning goals." In 1978 DHHS issued standards for several high cost hospital services. Section 1502 (300k-2) lists 17 "national health priorities" concerning such matters as the organization of health services, disease prevention, mental health, and competition. P.L. 96-79 added language about promoting competition in health care. Section 1503 (300k-3) establishes a National Council on Health Planning and Development to advise DHHS on the health planning program, especially on the national guidelines and on medical technology.

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[42] *Health Planning and Resources Development Amendments of 1979, P.L. 96-79. Legislative history: U.S. House of Representatives, Report No. 96-190, 96th Congress, 1st Session (1979); U.S. Senate, Report No. 96-96, 96th Congress, 1st Session (1979 U.S. Code, Congressional and Administrative News 1306); U.S. House of Representatives, Report No. 96-420, 96th Congress, 1st Session (conference report; 1979 U.S. Code, Congressional and Administrative News 1422).*

[43] *Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, §§933-937, 949(c)-(d). Legislative history: U.S. House of Representatives, Report No. 97-208, 97th Congress, 1st Session 822-23 (conference report; 1981 U.S. Code, Congressional and Administrative News 1010, 1184-85).*

[44] *P.L. 96-538, §§301-310.*

Section 1511 (300l) establishes criteria and procedures for designation of health service areas by DHHS. One Health Systems Agency (HSA) is designated and funded for each of the more than 200 such areas which were designated. This section also permits DHHS to revise area boundaries under certain circumstances. Area boundaries have been the subject of litigation. Section 1512 (300l-1) defines Health Systems Agencies (HSAs), the local health planning agencies under Title XV. It contains requirements concerning HSA legal structure (permitting private non-profit corporations, public regional planning bodies, or units of local government; most HSAs are the first), staff, governing body, liability (HSAs and members of their staff and governing body are granted immunity from liability for their actions under certain circumstances), private contributions (contributions to HSAs by providers are prohibited), and open meetings and records. The governing body requirements concern size, responsibilities, composition, selection, support, and conflicts of interest.[45] The last three requirements were added by P.L. 96-79. The composition language, which requires a consumer (i.e., non-provider) majority which is "broadly representative" of the area population, has been the subject of several lawsuits by low-income and minority groups seeking greater representation on governing bodies.

Section 1513 (300l-2) describes HSA functions, including data collection and analysis, development and adoption of a Health Systems Plan (HSP) and an Annual Implementation Plan (AIP), implementation of the HSP and AIP, coordination with other health and planning agencies, and collection and public dissemination of data on hospital services (the last was made optional by P.L. 97-35). The HSP, which is required to take into account the national guidelines (§1501), is a detailed statement of goals concerning existing health services in the area and how they should be changed. It must be adopted through a public process. P.L. 96-79 deleted a requirement that HSPs be "consistent with" the national guidelines and added requirements about specific types of services. Section 1513(e) (300l-2(e)) required review of certain Proposed Uses of Federal Funds (PUFF) authorized under the Public Health Service Act and other federal health laws. PUFF was made optional in 1981 by P.L. 97-35.

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[45] See J. Simpson, Conflict of Interest Policies for Health Systems Agencies (Western Center for Health Planning, 1981); T. Bogue, HSA Governing Body Composition and Selection (Western Center for Health Planning, 1980).

Section 1513(g) (300l-2(g)) required periodic review of institutional health services and submission of recommendations concerning their "appropriateness" to the State Health Planning and Development Agency (SHPDA), which makes public findings but is not required to impose any sanction on services found "inappropriate." The appropriateness review (AR) provision was a Congressional compromise between those who wanted to require states to have the legislative authority to close or "de-certify" existing facilities found to be unneeded, as a complement to CON authority, and those who wanted no review at all of existing facilities.[46] How AR should be defined and conducted has been controversial ever since. Several pending lawsuits challenge various aspects of AR, though none has yet resulted in a judicial opinion. States are not prohibited from enacting de-certification authority; New York has had it for many years but has infrequently used it. AR was made optional in 1981 by P.L. 97-35.

Section 1515 (300l-4) establishes requirements for conditional and full designation agreements with HSAs, based on the provisions of §§1512 and 1513, and for termination or return from full to conditional designation.

Section 1521 (300m) establishes requirements for DHHS' entering into conditional and full designation agreements with governors concerning State Health Planning and Development Agencies (SHPDAs), based on the provisions of §§1522 and 1523, for termination or return from full to conditional designation, and for reduction and withdrawal of federal health funds in states which have not complied with designation requirements (see next section for explanation of the last provision). Section 1522 (300m-1) requires states to submit to DHHS a "state administrative program," which must contain, inter alia, evidence that the SHPDA has legal authority to perform functions (such as CON) required by §1523 and requirements concerning staffing, review procedures and criteria, open meetings and records, and data collection. Section 1523 (300m-2) requires SHPDAs to perform these functions: (1) conduct health planning activities for the state government and determine statewide health needs (the latter was added by P.L. 96-79), (2) prepare a preliminary State Health Plan (SHP) to be made up of HSPs from HSAs within the state, (3) assist the Statewide Health Coordinating Council (SHCC), (4) conduct 1122 and CON review (see section on CON), (5) conduct AR (see description of §1513(g)), and (6) prepare an inventory and evaluation of health care facilities in the state (added by P.L. 96-79). Any of these functions may be performed by an agency other than the SHPDA under an agreement satisfactory to DHHS.

Section 1524 (300m-3) requires the governor to appoint a Statewide Health Coordinating Council (SHCC) to advise the SHPDA. It provides for representation of HSAs on the SHCC and requires a consumer majority. This section also requires the SHCC to review HSPs and AIPs from HSAs in the state, prepare the State Health Plan (SHP) based on HSPs and the SHPDA's preliminary SHP, and review other state plans

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[46] House Report No. 93-1382, supra note 14, at 64-65; Senate Report No. 93-1285, supra note 27, at 50-51 (U.S.C.C.A.N. 7889-90).

required by federal health programs. It contains immunity from liability and conflict of interest clauses similar to those for HSAs (§1512). The SHCC's most important function has been exercising final approval power over the SHP. In 1979, P.L. 96-79 added a number of detailed requirements about adopting the SHP, including the requirement that it must be approved by the governor before becoming effective.

Section 1531 (300n) defines statutory terms. "Provider of health care" is defined broadly to include fiduciaries of providers, individuals who receive income from providers, members of providers' families, and health insurers, in addition to providers involved in patient care. "Consumers" who do not have any of these provider ties must constitute a majority of HSA governing bodies and SHCCs. Other definitions are important in determining the extent of CON coverage (see section on CON issues).

Section 1536 (300n-5) until 1981 permitted territories and those small states (the provision was written to apply to Rhode Island) which had no local health departments, and prior to 1975 had a health planning system in substantial compliance with Title XV requirements, to have only a SHPDA and no HSAs. Rhode Island, Hawaii, and the District of Columbia qualified. In 1981 in P.L. 97-35, this section was amended to permit any governor who certified that his state could meet the purposes of Title XV without HSAs to request 1536 status. Requests from Ohio, Alabama, Louisiana, Missouri, Nebraska, Florida, Indiana, Kentucky, Maine, South Dakota, and Texas have all been granted.

Note on Federal Funding for Health Planning: Federal funding for health planning peaked in fiscal 1980, decreased in fiscal 1981, dropped dramatically in fiscal 1982, and has remained at a diminished level through 1984. By 1982, HSA budgets were no longer adequate to support all the functions mandated by federal law, and many HSAs ceased to exist. However, in mid-1984 there were approximately 150 HSAs continuing in operation.

In 1982 the statutory authorization for NHPRDA funding expired. From October 1982 through September 1985 the health planning program has been funded through a series of Continuing Resolutions, each of which provide for continued funding at the Fiscal Year 1982 level.[47] As of mid-1985, it was expected that the program would be similarly funded in FY1986.

Relationship of the National Health Planning and Resources Development Act to State Certificate of Need and 1122 Programs

One of the most difficult aspects of health planning law is the complex interaction among the different sources of CON "requirements": Title XV of the Public Health Service Act, the state CON statute, and Section 1122 (in states with 1122 contracts).

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[47] *See, Continuing Appropriations FY1983. Pub.L. No. 97-276, §133, 96 Stat. 1197; Further Continuing Appropriations 1983 Pub.L. No. 97-377, §101(e)(2), 96 Stat. 1905; Continuing Appropriations 1984 Pub.L. 98-107, §101(f), 97 Stat. 736; Pub.L. 98-151, §101(c), 97 Stat. 972; Continuing Appropriations 1985 Pub. L. 98-473 §101(d), 98 STAT. 1876 incorporating by reference ____________.*

If a state agrees to comply with Title XV's CON (and other) requirements, then DHHS will enter into a designation agreement with a State Health Planning and Development Agency (SHPDA). Under this agreement, DHHS will provide funds to the state to support the activities of the SHPDA and the Statewide Health Coordinating Council (SHCC) mandated by Title XV, including the operation of a CON program complying with federal requirements. If the state fails to meet all the compliance requirements for designation by a specified date, then funding of grants and contracts under several federal health authorities for any entity located in the state, including the state government, may phased out over a four-year period.[48] This funding amounts to tens or even hundreds of millions of dollars in most states. The specified date for most states was January 1983 and for no state was it later than January 1984.

Thus the federal government has given states powerful incentives to come into compliance with Title XV by making such compliance a condition of receipt of large amounts of federal health funds. However, the state is free to choose how it will respond to these incentives; no state is required to have a complying program or any program at all. Given the magnitude of federal funding involved, it is not surprising that every state has made an effort to comply with Title XV requirements.

However, although, every state does have a designated and funded SHPDA, few if any states fully comply with every Title XV requirement, especially those which were added in 1979 by P.L. 96-79. DHHS is permitted to continue funding non-compliant SHPDAs for the following reason. Since December, 1982 the Continuing Resolutions funding the health planning program have forbidden the Secretary of DHHS from terminating the designation agreement of non-complying states and HSAs or penalizing such HSAs and states.[49] As a consequence, the federal compliance incentives have been placed in suspense, and many states have chosen to retain non-complying programs, or to move out of compliance. As of mid-1985, it was expected that the health planning program would be funded by Continuing Resolution in FY1986, and that the Continuing Resolution would continue to suspend the Secretary's authority to penalize or terminate non-complying HSAs and SHPDAs.

Title XV is not a mandatory, self-executing exercise of federal regulatory authority. Consequently, the better view is that Title XV does not "pre-empt" inconsistent state laws under the supremacy clause in the U.S. Constitution, despite some case law which suggests the contrary.

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[48] §1521(d) [§300m(d)]. But see text and notes infra.

[49] See materials cited at note 47 supra.

The first step in researching any CON-related legal question is to obtain and examine carefully all relevant provisions in state law, administrative regulations and guidelines, and any judicial opinions interpreting these provisions. This does not mean, however, that the requirements of Title XV are irrelevant to state CON questions, for two reasons. First, because virtually all state legislation to enact or amend state CON laws after 1974 was, at least in part, an effort to comply with Title XV requirements, and because the federal law and regulations were the prime source of "model" CON language, most state laws now contain many provisions which repeat federal provisions either verbatim or in very similar language or incorporate federal provisions by reference. Second, many state laws since 1974 have compliance with Title XV as either an explicit or implicit purpose. Consequently, state courts will often interpret provisions of the state CON law to be the same as, or at least consistent with, Title XV provisions and regulations. This is particularly true in defining terms taken from the federal requirements. Thus, construction of state CON provisions will frequently require reference to the federal law, legislative history, and regulations. Finally, it is possible that some provisions of NHPRDA may be enforceable upon states that choose to enter into a designation agreement.

What if the state has a Section 1122 contract in addition to a state CON program, as many states still do? State participation in the 1122 program is currently voluntary. Though Congress specifically recognized 1122 in P.L. 93-641 and required that the SHPDA also be the 1122 "Designated Planning Agency" in 1122 states,[50] the states now receive no additional funds for having an 1122 contract, nor do they suffer a funding reduction in any program for not participating in 1122. However, if a state does enter into an 1122 contract, it must operate its program in accordance with Section 1122 and the regulations promulgated thereunder. States were not required to, and generally did not, enact state legislation explicitly authorizing 1122 review.

Title XV requirements and 1122 requirements concerning coverage, procedures, and criteria differ in a number of respects discussed in the next section. When a SHPDA conducts reviews under both a state CON law and an 1122 contract, it must follow not only all the requirements of the state law and regulations (which may or may not comply with Title XV) but also with 1122 requirements.[51] Title XV and Section 1122 are both administered by the Office of Health Planning, which has stated several times that Title XV and 1122 regulations will be interpreted to be the same, to the greatest extent possible within statutory constraints. However, OHP has not yet amended the 1973 1122 regulations in light of Title XV, though it has expressed its intention to do so.[52]

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[50] §1523(a)(4)(A)[§300m-2(a)(4)(A)].

[51] Chayet & Sonnenreich, supra note 31, at 3-4.

[52] Proposed amendments to the federal 1122 regulations were published at 48 Fed. Reg. 36390 (Aug. 10, 1983).

Section 1122 has also had some influence on state CON statutes, though not as much as Title XV. Because 26 states had 1122 contracts before passing a CON law, some 1122 terms and provisions have found their way into state statutes. In such cases, state courts may look to federal 1122 language as an interpretive guide, as they would look to Title XV for language derived from Title XV.

III. KEY LEGAL ISSUES IN CERTIFICATE OF NEED AND SECTION 1122

A wide range of issues has arisen in enacting, amending, and administering CON programs. The discussion that follows will include not only the major issues on which courts have ruled, the subject of this Guide, but also those issues which have sparked political controversy. These issues are grouped under the headings of constitutionality of CON statutes, scope of coverage, procedural issues, review criteria, and enforcement. Significant statutory and regulatory provisions concerning CON in Title XV, Section 1122, and state CON laws will be mentioned but not described in detail. The Guide user is referred to the provisions cited in the footnotes for exact and complete language. Judicial rulings on selected issues will be described in a general way. The organization of the Detailed Outline for "Section Three: Topical Digest of Health Planning and Certificate of Need Case Law" of the Guide is very similar to the organization of this section. Thus annotations of cases concerning the issues discussed here can be found quickly by referring to the Outline.

Constitutionality of CON Statutes

CON is an exercise of a state government's inherent "police power" to protect public health, safety, and welfare. It is a regulatory program in which a state administrative agency is delegated quasi-legislative and quasi-judicial powers by the legislature to grant or deny a certificate, similar to a permit or license, which is a legal pre-requisite to constructing or modifying a health care facility. CON differs from (though it is often linked to) ordinary licensure authority in that proposed projects are reviewed not for compliance with minimum standards of quality and safety but rather for compliance with standards of community "need." The (frequently unstated) rationale underlying CON is that for a number of reasons -- e.g., the non-profit status of most hospitals, a financing system and patterns of consumer behavior which stifle price competition, some elements of monopoly behavior, the inability to define and measure "health care" -- ordinary market forces will not operate to prevent the duplication of institutional services or the use of resources in an inefficient, uncoordinated, and wasteful manner.

Basic constitutional authority for state CON programs has been repeatedly upheld, though in a few cases courts have voided specific provisions in CON statutes on constitutional grounds. In addition, a Federal District Court has held that Title XV is constitutional even though a state might have to violate its state constitution to comply with it. The Court also pointed out that state compliance with the CON and other provisions of the Act was optional, not compulsory.

Scope of Coverage

Both political controversy and litigation about what entities and activities are subject to regulation by CON agencies are inevitable, since escaping the reach of the law is the most effective way for a lobbyist or lawyer to assure that his clients will avoid any unwanted restrictions. A large proportion of CON legal challenges, especially in the early years of state programs, has been related to coverage. Two questions are important in determining whether a particular project is subject to CON. First, what type of entity is undertaking the project? Second, exactly what kind of activities are being proposed? (A third question, whether the proposed activity had commenced before the statute's effective date, was litigated frequently in the early years of many state programs, especially those with "grandfather" clauses.) Major issues which have arisen in each of these areas are identified below. However, because coverage questions frequently are extremely complex, there is no substitute for a close, careful reading of the exact language and definitions found in your state law and regulations, any relevant federal provisions, and any judicial opinions interpreting the language or similar language in other states. Also bear in mind that, with some exceptions (such as HMOs), state coverage may be broader than Title XV requirements.

Entities Covered: The entities covered by CON generally include, and are limited to, inpatient, institutional health care facilities, the most capital-intensive part of the health care industry. As a rule the term "health care facilities" encompasses hospitals and nursing homes.[53] In 1977 the definition of "health care facility" in Section 1122 and Title XV regulations was made identical (1122 is, of course, limited to facilities certified for Medicare and Medicaid reimbursement). In addition to general, tuberculosis, and psychiatric hospitals, this definition of "health care facility" includes skilled nursing facilities, intermediate care facilities, kidney dialysis units (including freestanding units) and ambulatory surgical facilities.[54] (Rehabilitation facilities were added to Title XV by a 1979

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[53] Section 1122 and Title XV as adopted by P.L. 93-641 both covered HMOs in addition to health care facilities, as did many state laws. After a great deal of protest by HMOs all references to HMOs were deleted from Section 1122 (so that HMO-sponsored health care facilities were covered but HMO formation and outpatient facilities were not) in 1978 (Health Maintenance Organization Amendments of 1978, P.L. 95-559, §14(b)(1)-(3)). Coverage of HMO-sponsored health care facilities under 1122 was narrowed in 1983. (Social Security Amendments of 1983, p. 1. 98-21, §607(c), adding §1122(j).) Title XV was amended in 1979, 1980, and 1981 so that, in effect, states are prohibited from requiring CONs for virtually every HMO activity (See §1527(b) [§300m-6(b)]).

[54] 42 C.F.R. §§100.102(e), 123.401(b), added by 42 Fed. Reg. 4002, 4024, 4028 (Jan. 21, 1977). [hereinafter cited as "Jan. 77 FR"][Whenever C.F.R. sections are cited as being added or amended by a Federal Register notice, be advised that the notice usually also contains a preamble with responses by the regulation drafters to public comments concerning an earlier Notice of Proposed Rulemaking. These discussions are often invaluable in

amendment.[55]) Title XV requires coverage of facilities operated by state and local governments but not the federal government.[56] State CON law definitions of "health care facility" have been similar to the federal law (even before P.L. 93-641); CON coverage is often coterminous with licensure coverage, and licensure statute definitions of "health care facility" are often used in the CON statute.[57]

With the exception of the specialized facilities noted above and a few states which cover freestanding organized or group practice outpatient clinics, there has been little or no state CON coverage of non-institutional providers. In fact, many states explicitly exempt physicians' offices from coverage.[58] Several attempts to require CONs of such providers have resulted in litigation in which the courts have generally held for the providers. In the late Seventies, placement of CAT scanners in doctors' offices, medical office buildings, and in space leased from hospitals, in part to circumvent CON review, led to litigation and to considerable legislative controversy. After much debate, Congress included a compromise provision in the 1979 Title XV amendments, which required coverage of all major medical equipment having a cost greater than $150,000 (raised to $400,000 in 1981), wherever located, which is used for inpatients.[59] A number of states have extended coverage of medical equipment further, however, by covering medical equipment exceeding the threshold wherever located whether used for inpatients or outpatients. [59.5]

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[54] *[cont'd] interpreting the meaning and application of language in the regulations. This notice, for example, contains a discussion of the definition of "health care facility" on pp. 4005-06.]*

[55] *P.L. 96-79, §126(b), adding §1531(9) [§300n(9)]. 42 C.F.R. §123.401(6), added by 45 Fed. Reg. 69,740, 69,745 (Oct. 21, 1980) [hereinafter cited as "Oct. 80 FR"].*

[56] *Jan. 77 FR, at 4007 (the Federal government is not included within the definition of "person" for coverage purposes). In fact, constitutional considerations probably preclude states from subjecting Federal facilities to CON review.*

[57] *Ghayet & Sonnenreich, supra note 31, at 9-10.*

[58] *"Survey of State CON Laws," V Health Planning Law Reporter No. 2/3, at 3 (Jan. 31/Feb. 15, 1982).*

[59] *P.L. 96-79, §117(a), adding §1527(e)[§300m-6(e)]. Oct. 80 FR, at 69,747, 42 C.F.R. §123.404(a)(4). The definition and threshold for "major medical equipment" is at §1531(7)[§300n(7)]; Oct. 80 FR, at 69,746, 42 C.F.R. §123.401. P.L. 97-35, §936(c)(3), raised the threshold to $400,000. A majority of states have now adopted this provision. Survey, supra note 58, at 2.*

[59.5] *Colorado, Connecticut, District of Columbia, Hawaii, Iowa, Maryland, Montana, New Hampshire, Rhode Island, Virginia, Wisconsin.*

Activities Covered

Determining precisely which activities of these entities are subject to CON requirements is perhaps the most difficult and complicated aspect of the coverage issue. Many of the early CON statutes used general terms such as "establishment," "construction," "expansion," and "modification" of facilities.[60] Since enactment of Section 1122 and P.L. 93-641, however, statutory terminology has changed to include: obligation of capital expenditures; changes in bed capacity; offering of new services and substantial changes in services; and, in recent years, acquisition of major medical equipment.

Usually, all capital expenditures[61] by health care facilities above a fixed dollar threshold are covered. The 1122 threshold was $100,000 until 1983, when it was increased to $600,000 (or such lesser amount as a state may establish).[62] The minimum Title XV threshold was set at $150,000 in regulations published in 1977.[63] The 1979 Congressional amendments permitted the states to increase the threshold annually for inflation starting from a base of $150,000.[64] In 1981 the Federal law was amended again to increase the base threshold to $600,000.[65] Thresholds in state laws varied from zero to $350,000 in the early statutes.[66] After enactment of Section 1122 and P.L. 93-641, they were generally $100,000 or $150,000. At present, most states have thresholds at or above the maximums permitted by Title XV to focus limited staff resources on major projects.[67] States can also elect not to do 1122 review of small projects (which has the same effect as approval).[68]

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[60] W. Curran, "A National Survey and Analysis of State Certificate-of-Need Laws for Health Facilities," in Regulating Health Facilities Construction, supra note 1, at 85, 95-97.

[61] Section 1122 covers acquisitions by "lease or comparable arrangement" as well as by purchase. §1122(e)[§1320a-1(e)]; 42 C.F.R. §100.103(b) [hereinafter, all citations to Section 1122 of the Social Security Act will show the subsection of Section 1122 and of 42 U.S.C. §1320a-1, in brackets]. Title XV regulations contain the same language and add "donations" and "transfers." Oct. 80 FR, at 69,747, 42 C.F.R. §123.404(b).

[62] Social Security Amendments of 1983, P.L. 98-21, §607(b)(1)(A).

[63] Jan. 77 FR, at 4029, 42 C.F.R. §123.404(b)(1).

[64] P.L. 96-79, §117(b)(3)(ii), adding §1531(6)[§300n(6)]. Oct. 80 FR, at 69,745, 42 C.F.R. §123.401.

[65] P.L. 97-35, §936(a)(2).

[66] Curran, supra note 60, at 94-95.

[67] See Office of Health Planning, DHHS, Status Report on State Certificate of Need Programs (1983).

[68] 42 C.F.R. §100.106(a)(4)(ii).

CON laws also generally cover the offering of new services without any minimum capital expenditure requirement. Section 1122 covers any capital expenditure which "substantially changes" services. This language has been interpreted in regulations to mean addition of new clinical services or termination of existing services.[69] Title XV coverage is similar, except that, after the 1979 amendments, added services are covered only if they involve either $75,000 in annual operating costs (which was raised to $250,000 in the 1981 amendments and may be adjusted upward for inflation) or some capital expenditure.[70] Most but not all state laws provide for coverage of substantial changes of services in similar fashion.[71] What is a covered change in services has been an issue in several lawsuits; the specific question is usually whether a proposed new service has or has not been offered in the past.

Another important issue in the scope of CON coverage involves the connection between the covered entity and the covered activity. Since a covered activity by an entity which is not covered is not subject to CON review, providers have an obvious incentive to arrange matters so that such activities are legally sponsored by some entity other than a covered "health care facility." In response, legislators and regulators have tried to draft coverage provisions to prevent circumvention of CON review. Section 1122[72] and Title XV[73] both cover capital expenditures "by or on behalf of" health care facilities. Surprisingly, this term has not yet been thoroughly analyzed in a judicial opinion.[74] However, lawsuits have presented fact situations which involve the connection between hospitals and affiliated activities (such as a CAT scanner in a medical office building adjacent to a hospital). This issue is likely to arise in future litigation, given the current trend toward hospital reorganization into multiple corporate entities.

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[69] §1122(g)(3)[§1320a-1(g)(3)]. 42 C.F.R. §100.103(a)(2)(iv).

[70] §1531(5),(6)(B)(ii)(iii)[§300n(5),(6)(B)(ii)(iii)]. Oct. 80 FR, at 69,747, 42 C.F.R. §123.404(a)(3). Compare former regulation, Jan. 77 FR, at 4029, 42 C.F.R. §123.404(a)(4). The 1981 amendment was P.L. 97-35, §936(c)(1).

[71] *See, e.g.*, Chayet & Sonnenreich, *supra* note 31, at 11; Survey, *supra* note 58, at 2.

[72] §1122(b)(1)[§1320a-1(b)(1)]. 42 C.F.R. §100.103.

[73] §1531(6)(A)[§300n(6)(A)]. Oct. 80 FR, at 69,746, 42 C.F.R. §123.404(a)(1). Title XV also covers *services* offered "by or on behalf of" health care facilities. Oct. 80 FR, at 69,747, 42 C.F.R. §123.404(a)(3).

[74] *But see District of Columbia v. Washington Hospital Center Health System and Properties, Inc.* at p. 77 *infra*.

Procedural Issues

Local CON Review: Local review is now done by HSAs, which make non-binding recommendations to SHPDAs. Before the formation of HSAs, CHP "b" agencies, where they existed, conducted sub-state CON review under both 1122[75] and CON programs.[76] Section 1122 says nothing about the process of local review. With some exceptions, most early CON statutes also contained very little about local review procedures.[77] Title XV, however, has a list of eleven procedural requirements which apply to both HSAs and SHPDAs (and to PUFF and appropriateness review as well as CON).[78] These requirements have been further elaborated in regulations.[79] Parallel requirements for SHPDA review are discussed below. HSAs are required to hold a public hearing concerning a CON application on request. The hearing must provide an opportunity for any person to be heard but may be very informal.[80] HSAs are also required to make written findings supporting their recommendations to the SHPDA concerning applications,[81] and to comply with conflict of interest requirements.[82] Because HSAs only make CON recommendations[83] rather than final decisions, their procedures have seldom been challenged in court.

State Administrative Review: State CON statutes have lodged the legal authority to grant or deny certificates in a bewildering variety of state agencies. The CON agency may be part of the state Hill-Burton agency, the CHP "a" agency, the health department, and/or the health facility licensure agency, but other agencies are also used. In many states the final CON decision-maker is a board or commission made up of gubernatorial appointees.[84] It is also not unusual for health planning and CON functions to be split among two or more state agencies, a situation which remained permissible, within limits, under Title XV SHPDA requirements.[85] Section 1523 requires the SHPDA both to administer the state CON program and to serve as the 1122 "Designated Planning Agency" (DPA) if the state has an 1122 contract.[86]

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[75] §1122(d)(1)(B)(ii)(I)[§1320a-1(d)(1)(B)(ii)(I)].

[76] Curran, supra note 60, at 97-103.

[77] Id.

[78] §1532(b)[§300n-1(b)].

[79] Oct. 80 FR, at 69,743, 42 C.F.R. §122.308.

[80] Id. §122.308(a)(8).

[81] Id. §122.308(a)(6).

[82] Id. §122.308(a)(11).

[83] Title XV requires the SHPDA to transmit detailed, written reasons to the HSA for decisions which do not follow the HSA's recommendations. §1523(c) [§300m-2(c)]. Oct. 80 FR, at 69,751, 42 C.F.R. §123.410(a)(10).

[84] Alpha Center, Redesigning State Health Programs 10 (1983).

Four major types of procedural issues have arisen in SHPDA review of CON applications: (1) whether procedural requirements from various sources of legal authority apply to such review proceedings; (2) the timeliness of SHPDA actions regarding the application; (3) entitlement to and conduct of review hearings; and (4) entitlement to and conduct of administrative appeal proceedings.

Sources of CON procedural requirements include constitutional due process clauses and state Administrative Procedure Acts as well as Section 1122, Title XV, and state CON laws. Courts are split on whether CON applicants have a sufficient property interest in a CON to be protected by constitutional due process requirements. CON review is also either expressly or implicitly subject to the procedural requirements of state Administrative Procedure Acts under many state CON statutes, but courts have held that state APAs do not apply in some states, permitting SHPDAs to conduct review according to procedures derived from the CON law and administrative regulations. Section 1122 requires participating states to establish review procedures in accordance with federal regulations.[87] Title XV requires SHPDAs to follow the same general procedures as HSAs.[88] In 1979 Congress added more detailed and stringent procedural requirements concerning state-level CON review.[89]

The timeliness of state CON and 1122 review has received a good deal of attention from the courts. Under Section 1122 the applicant must submit to the DPA a notice of the intention to make a capital expenditure at least 60 days prior to incurring the expenditure (failure to do so is a basis for imposing the reimbursement sanctions[90]). If the DPA fails to notify the applicant of its decision within, at most, 90 days of this notice of intent, the capital expenditure is "deemed approved."[91] Title XV requires review to be completed, "to the extent practicable," within 90 days of the date that the SHPDA notifies the applicant and others of the beginning of review (at least 60 days must be allowed for HSA review).[92] Prior to 1979, complying state CON programs had to provide that, if the SHPDA failed to make a decision within the 90-day time limit, the application would be deemed denied, directly contrary to the 1122 requirement.[93] A 1979 amendment provides that if the SHPDA fails to reach a timely decision the applicant is entitled to seek a state court order requiring a decision, but the application may not be deemed either approved or denied.[94] Time limits for review set by state CON laws have been at issue in a number of lawsuits.

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[85] §1523(b)(1) [§300m-2(b)(1)].

[86] §1523(a)(4) [§300m-2(a)(4)].

[87] §1122(b)(3)[§1320a-1(b)(3)]. 42 C.F.R. §100.106(a).

[88] §1532(b)[§300n-1(b)].

[89] P.L. 96-79, §116(d)(3), adding §1532(b)(12)[§300n-1(b)(12)].

[90] §1122(d)(1)(A)[§1320a-1(d)(1)(A)]. 42 C.F.R. §§100.106(a)(1), 100.108(a)(1).

[91] §1122(d)(1)(B)(i)[§1320a-1(d)(1)(B)(i)]. 42 C.F.R. §100.106(a)(4).

The right to a hearing is one of the most fundamental elements of administrative due process. The hearing requirement under Section 1122 is for a "fair hearing" (actually an administrative appeal of the DPA decision; see below). Title XV requires that the SHPDA conduct a "public hearing in the course of agency review" on request.[95] The 1979 amendments added a number of hearing requirements, including the right to counsel, to offer arguments and evidence, to "conduct reasonable questioning" concerning factual questions, and to have a record maintained. The authority to conduct this hearing can be delegated by the SHPDA to the HSA.[96] SHPDAs also must conduct a public hearing to "reconsider" their CON decision if the requester shows "good cause."[97]

State CON agencies have made increasing use of "batching" and comparative review of CON applications in recent years. Under Section 1122 and under many state CON laws, concurrent consideration of multiple applications for similar services is not possible because the DPA/SHPDA lacks discretionary authority to delay review of one application in order to batch it with others.[98] Title XV requirements permitted, but did not require, batching until 1979, when an amendment added a requirement that applications for "similar" services in the same area "be considered in relation to each other" at least twice a year.[99] Regardless of statutory requirements, the Ashbacker judicial doctrine may require "mutually exclusive" competing applications to receive a comparative hearing.

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[92] §1532(b)(2)[§300n-1(b)(2)]. Oct. 80 FR, at 69,750, 42 C.F.R. §123.410(a)(3)(ii)-(iii).

[93] Jan. 77 FR, at 4031, 42 C.F.R. §123.407(a)(15).

[94] P.L. 96-79, §116(d)(3), adding §1532(b)(12)(C)(ii) [§300n-1(b)(12)(C)(ii)]. Oct. 80 FR, at 69,752, 42 C.F.R. §123.410(a)(17).

[95] §1532(b)(8)[§300n-1(b)(8)].

[96] §1532(b)(12)(A)[§300n-1(b)(12)(A)]. Oct. 80 FR, at 69,750-51, 42 C.F.R. §123.410(a)(8).

[97] §1532(b)(8)[§300n-1(b)(8)]. Oct. 80 FR, at 69,751, 42 C.F.R. §123.410(a)(11).

[98] *See* note 91 *supra*.

The procedures for administrative appeals of CON decisions have caused confusion, controversy, and some litigation. An administrative appeal is available to disappointed applicants or other parties seeking review of the decision of the state CON agency by an independent state administrative body. Section 1122 requires participating states to provide for a "fair hearing" conducted by an independent hearing officer "with respect to," *i.e.*, after, the DPA's decision.[100] The DPA's findings and recommendations (which may have been reversed or revised by the hearing officer) are then transmitted to DHHS. If DHHS determines either that the applicant did not give the DPA timely notice or that the DPA, according to proper procedures, found that the application did not conform to 1122 standards, then DHHS must exclude expenses related to the capital expenditure from Medicare and Medicaid reimbursement[101] (except under special circumstances described in the law[102]). In addition, any person may request reconsideration of a DHHS 1122 decision (by DHHS) within six months of the decision.[103]

Title XV regulations published after P.L. 93-641 required that states provide for independent administrative appeals of SHPDA decisions if requested by either HSAs or applicants (though the statutory provision mentioned only HSAs).[104] Congress in 1979 added a provision which explicitly required states to provide for administrative reviews (and also for judicial review).[105] Subsequent DHHS regulations, however, did not require states to bar judicial review to those who had not first obtained an administrative review.[106] Finally, in 1980 Congress amended this provision so that the review had to be consistent with the state APA but did not necessarily have to be conducted by an administrative agency (i.e., appeal could be made directly from the SHPDA to the courts).[107] Both 1122 and Title XV leave questions about the procedural conduct of administrative appeals to state law.[108]

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[99] §1532(b)(13)(A)(iii)[§300n-1(b)(13)(A)(iii)]. Oct. 80 FR, at 69,750, 42 C.F.R. §123.410(a)(1).

[100] §1122(b)(3)[§1320a-1(b)(3)]. 42 C.F.R. §100.106(c).

[101] §1122(d)(1)[§1320a-1(d)(1)]. 42 C.F.R. §100.108(a).

[102] §1122(d)(2)[§1320a-1(d)(2)]. 42 C.F.R. §100.108(b).

[103] §1122(f)[§1320a-1(f)]. 42 C.F.R. §100.108(d).

[104] Jan. 77 FR, at 4031, 42 C.F.R. §123.407(a)(10).

[105] P.L. 96-79, §116(d)(3), adding §1532(b)(12)(D), (E)[§300n-1(b)(12)(D), (E)].

[106] Oct. 80 FR, at 69,751, 42 C.F.R. §123.410(a)(13), (14).

State CON laws generally provide for an administrative appeal, but the identity of the appeals body varies from state to state. It may be a hearing officer appointed ad hoc, a special CON appeals body with gubernatorial appointees, a SHCC, or a state official or agency responsible for hearing appeals from all state regulatory agencies.[109] Though they have not been frequently litigated, some issues concerning administrative appeals procedures have arisen. One issue is who has standing to obtain an administrative appeal. The 1122 states only have to grant "fair hearings" to applicants, while Title XV now requires that administrative (and judicial) reviews be granted to all "affected persons," defined very broadly.[110] There has been a great deal of confusion about the conduct and timing of, and distinctions among, the public hearing in the course of review (for both HSAs and SHPDAs), the reconsideration hearing, the administrative review, the 1122 fair hearing, and the "contested case" hearing required by state APAs. This problem has been compounded by the fact that state laws and regulations often use these labels differently from the federal law or from other states.

Judicial Review:

It is generally settled law that final administrative decisions regarding certificate of need applications are subject to judicial review in the trial courts of the state which granted or denied the CON. Provision for judicial review is required under NHPRDA for a complying CON program (42 U.S.C.A. §300n-1(b)(12)(E); Public Health Service Act §1532(b)(12)(E)). State CON statutes typically either provide expressly for judicial review or incorporate by reference state Administrative Procedure Act provisions allowing judicial review.

Two issues concerning judicial review of CON decisions have been litigated frequently. One is the availability of any judicial review of 1122 decisions. The other is the standing of various parties to obtain judicial review of either 1122 or CON decisions.

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[107] *P.L. 96-538, §310, amending §1532(b)(12)(D)[§300n-1(b)(12)(D)].*

[108] *See notes 100, 106 supra.*

[109] *See P. Bramson, G. Clarke, & R. Neuman, A Legislative Snapshot: Certificate of Need 14-16 (1980).*

[110] *§1532(b)(12)(D), (E)[§300n-1(b)(12)(D), (E)]. Oct. 80 FR, at 69,745, 69,751-52, 42 C.F.R. §§123.401, 123.410(a)(13), (14).*

availability of judicial review of 1122 decisions has been an issue in more lawsuits than perhaps any other single issue in health planning law. In part this is a result of the fact that there are "decisions" at both the state and federal levels concerning each 1122 applicant which can conceivably be reviewed by either the state or federal courts. Courts have divided on the availability of judicial review by state courts of state DPA decisions, with courts which deny review emphasizing that DHHS, not the DPA, makes the final decision, and courts which permit review stressing that DHHS authority to overturn the DPA recommendation is extremely limited. Plaintiffs seeking federal court review of DPA decisions have sometimes been successful despite language in Section 1122 precluding judicial review.[111] Finally, where plaintiffs have sought federal judicial review of DHHS decisions, the courts have generally followed the preclusion-of-review provision and denied review, with certain exceptions to allow review for procedural errors.[112]

Standing to obtain judicial review of 1122 and CON determinations has also been heavily litigated. Section 1122 requires states to grant applicants administrative "fair hearings" but is silent concerning standing for judicial review. Title XV requires that judicial review be available to all "persons adversely affected," a term which is defined extremely broadly to include HSAs and all health consumers and providers in the applicant's area, and others.[113] Because state laws and state courts have been either silent or much more restrictive -- limiting standing to applicants or formal parties to the administrative proceedings or "persons aggrieved," for example -- standing has been an issue in many cases. While applicants have been granted standing in all the decided cases, courts have divided on the standing of competitors, of HSAs, and of other consumer and taxpayer groups. Finally, there are several interesting opinions regarding the standing of HSAs and citizen groups to enforce the CON law by, for example, seeking to enjoin the offering of services which allegedly require, but have not been granted, a CON.

Review Criteria and Standards

This section will consider four topics concerning CON review criteria and standards which have been addressed by legislatures and/or courts: (1) Section 1122 and Title XV provisions; (2) general questions concerning adoption and use of criteria and standards by state CON agencies; (3) interpretation of "need" criteria; and (4) judicial scope of review of the substantive merits of CON decision-making.

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[111] §1122(f)[§1320a-1(f)]. See First Federal Savings and Loan Association v. Casari 667 F.2d 734 (8th Cir. 1982).

[112] See Hollingsworth v. Harris 608 F.2d 1026 (5th Cir. 1979).

[113] See note 110 supra.

[114] §1122(b)[§1320a-1(b)].

Federal Law: Section 1122 itself is virtually silent about DPA criteria, except for a reference to CHP and other PHS Act plans.[114] The 1122 regulations, however, also list four general criteria concerning community need, staffing, financial feasibility, and cost containment, which must be included in DPA criteria.[115] Title XV has a much longer list of "considerations" (which became even longer with the 1979 amendments) upon which both HSA and SHPDA CON review criteria must, at a minimum, be based. These considerations refer to such matters as relationship to agency plans, need, alternative approaches, use of similar existing services, accessibility, costs, effect on competition, and quality of care.[116] Title XV permits agencies to vary the application of criteria depending on the service being reviewed.[117] Much more specific, quantitative standards for several specialized or expensive acute care services are contained in the national guidelines promulgated by DHHS, but HSAs and SHPDAs are not bound to follow them in their plans.[118] However, a 1979 amendment did require that all state CON decisions must "be consistent with" the State Health Plan except in emergencies.[119] Many states, however, have not adopted such a requirement in state law. Most state CON laws now contain the Title XV criteria with minor variations.

General State Criteria Issues: In the early years of state CON programs, these issues arose frequently: had the state agency established adequate criteria at all and had the criteria been adopted through the proper, legally required process? On the latter question, courts have tended to hold that rules of general applicability, implementing the CON statute and binding on regulatees, must be adopted as regulations, but that statistical guidelines need not be.

There are a large number of cases concerning changes in criteria and statistical data while applications are pending. The general issue raised is whether a state agency which adopts new criteria or data while a CON application is pending may deny the application on the basis of the new criteria or data, when the application would have been approved under the old criteria or data being used at the time the application was submitted. The overwhelming majority of courts presented with this issue have held for the state agencies, reasoning that regulatory agencies must be permitted to change criteria and data as objective circumstances change (though the agency must demonstrate a rational basis for the change) and must not be "locked into" using outdated standards adopted at an earlier time.

Whether state CON agencies have the authority to attach conditions to CON approvals has been a politically controversial issue. In response

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[115] 42 C.F.R. §100.107.

[116] §1532(c)[§300n-1(c)]. Oct. 80 FR at 69,752-53, 42 C.F.R. §123.412(a).

[117] §1532(a)[§300n-1(a)]. Oct. 80 FR, at 69,753, 42 C.F.R. §123.412(b).

[118] 42 C.F.R. §§121.1-121.211.

[119] §1527(a)(5)(B)(ii)[§300m-6(a)(5)(B)(ii)]. Oct. 80 FR, at 69,746, 42 C.F.R. §123.403(d).

to complaints from providers that SHPDAs were exceeding their statutory authority in conditioning approvals on matters not within legislative intent or not related to the project under review, the 1979 amendments to Title XV added a provision that permits SHPDAs to attach a condition which "directly relates to" criteria in federal or state law or regulations.[120] Some state CON laws further restrict the SHPDA's conditioning authority. The complex implications of this issue are discussed in a Western Center for Health Planning document.[121] The meaning of the Title XV language has not been litigated, but a number of cases have discussed CON conditions and generally upheld their use.

Courts have ruled on a number of other issues related to the general use of criteria in CON review. Courts have held that state agencies must "consider" all the statutory CON criteria rather than relying on a single criterion, though the agencies are permitted to exercise considerable discretion in determining compliance with criteria. In several cases, courts have dealt with a claim that a state agency decision was "inconsistent" with a prior decision. In general, they have held that agencies are not rigidly required to treat every applicant the same way, but adequate reasons must be given for any apparent inconsistency. A number of special considerations apply to use of criteria in comparative or "batched" reviews, an area which is sure to receive more judicial attention in the future.

"Need" Criteria: The single most important criterion in most CON reviews is whether the proposed project is needed by the community; lack of community need is probably the most common basis for denial of a CON. Consequently, it is not surprising that the development and application of need criteria have been frequently litigated in CON cases. Health planning agencies often use quantitative formulas and data to project need for facilities and services. In several cases, courts have held that it is error for agencies to rely exclusively on numerical need formulas without consideration of other statutory criteria. Courts are split on whether it is impermissibly arbitrary for state agencies to use county boundaries in establishing service areas for purposes of determining need for services. Another general issue in need projection -- which existing facilities and services in which geographic areas are counted toward fulfilling community need -- has been considered in several cases. Applicants frequently argue that their proposed services are unique or will serve the unique needs of a special population group; judicial resolution of this issue, which has arisen in a number of lawsuits, depends heavily on the facts and arguments involved in the specific case; but it is clear that a claim of "uniqueness" must be supported by specific factual evidence.

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[120] §1527(a)(2)[§300m-6(a)(2)]. Oct. 80 FR, at 69,752, 42 C.F.R. §123.412(a).

[121] J. Simpson, Conditions on Certificate of Need Approvals (Western Center for Health Planning, 1980).

Judicial Review of the Substance of CON Decisions: One of the settled principles of judicial review of administrative action is that courts should limit the scope of their review in order to avoid impinging upon agencies' discretionary judgment in a specialized subject matter area. The applicability and interpretation of this general standard, most commonly labeled the "substantial evidence" rule, has been at issue in a number of CON cases. The substantial evidence rule, though generally deferential to the agency, requires that the agency be able to explain how the evidence in the record supports the conclusions it reached regarding compliance or non-compliance with CON criteria. Thus, state APAs, state CON laws, Title XV requirements[122], and the courts on their own often require that CON decisions be accompanied by "findings" which state the basis for a decision. Whether and to what extent findings are required has been an issue in several cases.[123]

Enforcement of CON Decisions

The major difference between Section 1122 and state CON programs lies in the enforcement mechanism. Under Section 1122, if a proposed capital expenditure is disapproved by the DPA and DHHS, then DHHS must exclude from federal payments under Medicare and Medicaid all "depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure."[124] However, neither the DPA nor DHHS has legal authority to prohibit or otherwise penalize the facility for making such a capital expenditure. As a practical matter, any facility which has, or expects, a substantial number of federal program patients, is unlikely to proceed with the expenditure.

By contrast, Title XV now explicitly requires state CON programs to "provide for procedures and penalties to enforce the requirements of the program."[125] The regulations make clear that the state must have authority to prohibit expenditures and new services which are denied a CON by "sanctions, such as the denial or revocation of a license to operate, civil or criminal penalties, or injunctive relief."[126] Every state CON law provides for some combination of these sanctions. The nature and application of the sanctions themselves has not been a subject of litigation.

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[122] §1532(b)(6)[§300n-1(b)(6)]. Oct. 80 FR, at 69,750, 42 C.F.R. §123.410(a)(6).

[123] See T. Bogue & J. Simpson, Bridging the Analytical Gap: Guidance on Documenting and Rationalizing Certificate of Need Decisions (Western Center for Health Planning 1982).

[124] §1122(d)(1)[§1320a-1(d)(1)].

[125] §1523(a)(4)(B)[§300m-2(a)(4)(B)].

[126] Oct. 80 FR, at 69,749, 42 C.F.R. §123.408(b).

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I. STRUCTURE OF THE HEALTH PLANNING PROGRAM

A. CONSTITUTIONALITY OF HEALTH PLANNING STATUTES

1. Constitutionality of National Health Planning and Resources Development Act of 1974, as amended; Title XV, Public Health Service Act; 42 U.S.C. §300k et seq., hereafter "NHPRDA.")

a. Goodin v. Oklahoma ex rel. Oklahoma Welfare Commission 436 F.Supp. 583 (W.D. Okla. 1977)

A nursing home which had been denied a CON brought an action seeking declaratory and injunctive relief and alleging that NHPRDA's requirement that participating states adopt complying CON programs violated the Tenth Amendment and the Due Process Clauses of the Fifth and Fourteenth Amendments. The Court held that: (1) NHPRDA did not violate the Tenth Amendment because it clearly fell within Congress' general welfare authority and Congress may impose terms and conditions upon valid money allotments to states; and (2) NHPRDA did not violate due process because its requirement that there be an approved state certificate of need program before federal funds may be distributed to a State: (a) does not require a state to adopt a CON program; (b) is rationally justified by convincing evidence before Congress that overbuilding of facilities is responsible for the high cost of medical services; and (c) is a reasonable requirement to achieve its purpose.

b. North Carolina ex rel. Morrow v. Califano 445 F.Supp. 532 (E.D.N.C. 1977), aff'd mem., 435 U.S. 962 (1978)

North Carolina brought an action against the Secretary of DHHS challenging the constitutionality of NHPRDA's requirement that a participating state adopt a complying CON program as a condition of participation and receipt of federal funds. The North Carolina Supreme Court had held the state's CON law void under the state constitution. [Cf. In re Certificate of Need for Aston Park.] North Carolina alleged that compliance would require a state constitutional amendment, and that such a requirement would be unconstitutionally coercive. (1) The Court held that the provisions of NHPRDA which condition the state's receipt of funds under the Public Health Service Act on adoption of a complying CON program do not violate the due process clause, the guaranty clause, or the Tenth Amendment of the U.S. Constitution because the purposes of NHPRDA are related to a legitimate national interest in health and, that being the case, it would seem manifest that the federal government could validly attach a condition which was intended to assure the efficient use of the funds so granted. (2) The Court held that NHPRDA would not be rendered void by the fact that to adopt a complying program a state might have to violate the state Constitution because: (a) were that so, any state dissatisfied by some valid federal condition could thwart the Congressional purpose by the expedient of amending its Constitution or by securing a decision of its own Supreme Court; (b) the economic injury to the state from loss of federal monies as a consequence of NHPRDA termination would not be so great relative to total state revenues as to be catastrophic or coercive; and (c) NHPRDA is not coercive because it does not impose a mandatory requirement that states enact legislation but instead gives them the option to do so and offers financial assistance to induce enactment. (3) The Court held that NHPRDA does not unlawfully interfere with the physician-patient relationship in violation of the First, Fifth, and Ninth Amendments. (4) The Court also held that NHPRDA is not unconstitutionally arbitrary and irrational by virtue of requiring health service areas to contain at least five hundred thousand persons because Congress legitimately concluded that effective planning of health care requires a base of population and health resources of that size.

c. Montgomery County, Maryland v. Califano 449 F.Supp. 1230 (D. Md. 1978), aff'd 599 F.2d 1048 (4th Cir. 1979)

A county brought an action against DHHS seeking declaratory relief and alleging among other things that: (1) NHPRDA violated the Guaranty Clause by creating a local health planning decision-making process pursuant to which DHHS was authorized to designate and select HSAs which were not accountable to local government; and (2) NHPRDA violated the Tenth Amendment by creating HSAs and SHCC's unaccountable to local citizens, thereby depriving state and local government of real responsibility or control over planning and regulation of local health services. The Court held that NHPRDA did not violate the Guaranty Clause because no standards for judicial enforcement of the Guaranty Clause have been established and on its face NHPRDA hardly seems to approach a denigration of republican government. The Court held that NHPRDA did not violate the Tenth Amendment because: (a) NHPRDA served a legitimate national end of achieving more efficient and equitable organization, supply, and distribution of health resources through coordinated planning; (b) NHPRDA was well within Congress' power under the General Welfare Clause; and (c) NHPRDA provisions regarding HSA's and local goverments did not coerce states into surrendering their sovereignty because NHPRDA did not compel participation and compliance but instead simply induced states to act in a particular way by the promise of federal funds.

2. Constitutionality of Federal "Section 1122" Statute (42 USCA §1320a-1 et seq.)

a. Wilmington United Neighborhoods v. United States 615 F.2d 112 (3rd Cir. 1980), cert. denied 449 U.S. 827 (1980)

Consumers of medical services sought judicial review of a DPA decision recommending approval for reimbursement under Section 1122 of a project to relocate hospital services from the inner city to suburban Wilmington. They argued that Section 1122(b)(3), which provides that participating state programs shall establish and maintain procedures whereby proponents of capital expenditures may appeal a DPA recommendation and be granted a fair hearing, violated their right to equal protection as guaranteed by the Fifth Amendment, in that Section 1122(b)(3) did not require the offering of the same appeal right to opponents of a capital expenditure. The Court held that the provision was not unconstitutional because providing appeal rights only for proponents was a rational means for streamlining 1122 review proceedings and avoiding delay of necessary projects.

3. Constitutionality of State Statutes

a. Substantive rationality

(1) Statute constitutional

(A) Attoma v. State Department of Social Welfare 270 N.Y.S.2d 167 (App. Div. 1966)

A nursing home brought an action seeking, among other things, a declaratory ruling that the state CON statute was unconstitutional because not a reasonable exercise of the state's police power. The Court held that the operation of nursing homes bears a reasonable relation to the health, safety and welfare of the community and is subject to licensing and regulation as a valid exercise of the police power. The Court further ruled that the legislatively-identified proliferation of such homes beyond the needs of geographical areas, with spiraling costs to the users thereof, bore a similar reasonable relation to the welfare of the community and that regulation of such proliferation may not be found to be an invalid exercise of the police power.

(B) Goodin v. Oklahoma ex. rel Oklahoma Welfare Commission 436 F.Supp. 583 (W.D. Okla. 1977).

A nursing home denied a CON brought an action challenging the constitutionality of the state CON statute. The Court held that the state certificate of need statute covering nursing home construction or expansion was reasonably related to a legitimate governmental interest because it is well recognized that the operation of an institution for the shelter, feeding and care of the sick, aged or infirm bears a reasonable relation to the health, safety and welfare of the community and is subject to licensing and regulation as a valid exercise of the police power of the state.

(C) Merry Heart Nursing and Convalescent Home, Inc. v. Dougherty 330 A.2d 370 (N.J. Super. App. Div. 1974)

A nursing home brought an action seeking judicial review of a state CON appeals board decision on its application for a CON to add beds to its facility. The nursing home alleged that the state CON statute was unconstitutional because the legislature lacked authority to regulate the growth and expansion of private, proprietary nursing homes. The Court rejected this argument, holding that the state CON requirement was a valid exercise of the state's police power to regulate in the field of public health and the legislature had the authority to control various facets of medical, hospital, and healthcare practices and facilities without regard to whether they were private or public.

(D) North Charleston Medical Center, Inc. v. South Carolina Department of Health and Environmental Control No. ______ (S.C.County Ct. Charleston County Nov. 21, 1975), reprinted in HOSPITAL FRANCHISING LAW AND REGULATION (A SOUTH CAROLINA CASEBOOK) 369 (1979)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to construct a new facility. The hospital alleged that the state CON statute was unconstitutional under the due process clause of the state constitution because it went beyond regulating existing hospitals to create a barrier to entry in the hospital field. The Court held that the regulation of entry into the hospital field through the CON mechanism was reasonably related to the promotion and protection of public health and therefore valid under the due process clause.

(E) Mount Royal Towers Inc. v. Alabama State Board of Health 388 So.2d 1209 (Ala. 1980)

A nursing home brought an action seeking, among other things, a declaratory judgment that the state CON statute violated the due process clause of the state constitution. The Court held that the statute did not violate the due process clause because, although the statute's restriction of entry into a field of economic endeavor was a severe infringement on individual contract and the property rights, there was no indication that the elimination of surplus hospital beds in a community through licensing and CON laws was not logically calculated to reduce medical costs caused by duplication of services.

(2) Statute unconstitutional

(A) In re Certificate of Need for Aston Park 193 S.E. 2d 729 (N.C. 1973).

A hospital which was denied a CON to construct a new facility sought judicial review challenging, among other things, the constitutionality of the state CON statute. The Court held that the statute violated the due process clause of the state constitution because it was not a reasonable means to allocate health services, where the record did not show that the marketplace could not allocate appropriately and where the effect of the CON statute was to establish monopolies without the protections to the public from the customary effects of monopoly provided by full public utility regulation.

b. Equal Protection

(1) North Charleston Medical Center, Inc. v. South Carolina Department of Health and Environmental Control No. ___ (S.C. County Ct. Charleston County Nov. 21, 1975), reprinted in HOSPITAL FRANCHISING LAW AND REGULATION (A SOUTH CAROLINA CASEBOOK) 369 (1979)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to construct a new facility. The hospital alleged that the state CON statute was unconstitutional under the equal protection clause of the state constitution. The Court held that the state legislature's classification of applicants for construction and operation of hospitals as a class subject to the franchising requirements of the CON law bore a reasonable relation to the public health and welfare protective purposes of the law.

(2) Wilmington United Neighborhoods v. United States 615 F.2d 112 (3rd Cir. 1980), cert. denied 449 U.S. 827 (1980)

Consumers of medical services sought judicial review of a DPA decision recommending approval for reimbursement under Section 1122 of a project to relocate hospital services from the inner city to suburban Wilmington. They alleged that the provisions of the state 1122 program implementing 1122(b)(3), which limits the right to administratively appeal DPA recommendations on proposed capital expenditures to proponents of capital expenditures, were unconstitutional, as a violation of their rights under the equal protection clause of the Fourteenth Amendment. The Court held that the state provision was not unconstitutional because providing appeal rights for proponents only was a rational means for streamlining 1122 review and avoiding delay of necessary projects.

(3) Paul Kimball Hospital, Inc. v. Brick Township Hospital, Inc. 432 A.2d 36 (N.J. 1981)

A hospital brought an action challenging the constitutionality, under the Equal Protection Clause of the Fourteenth Amendment and the prohibition on special legislation in the state constitution, of a state statute exempting from CON those hospital construction projects for which land located within a municipality had been acquired and municipal funds appropriated prior to the effective date of the CON statute. The statute had the effect of exempting one proposed facility, plaintiff's competitor, from CON. The Court held that: (1) the statute did not violate equal protection because it was reasonable for the legislature to single out the hospital classified by the statute as entitled to a grandfather exemption since: (a) a governmental entity (the municipality) had judged it necessary; and (b) the proponents of the proposed facility had acquired the land in good faith reliance on the state of the law prior to the CON statute; and (2) the statute was not impermissible special legislation because it was based on a classification rationally justified by the municipal government's identification of need and the proposed facility's acquisition of land in reliance on prior law.

c. Unlawful Delegation of Legislature's Discretionary Authority to an Administrative Agency

(1) Merry Heart Nursing and Convalescent Home, Inc. v. Dougherty 330 A.2d 370 (N.J.Super.App.Div. 1974).

A nursing home brought an action seeking judicial review of a state CON appeals board decision on its application for a CON to add beds to its facility. The Court held that the state law, which set forth general CON criteria concerning need, financial feasibility, available alternatives, etc., to be enlarged upon by regulation, was not so indefinite as to be an unconstitutional delegation of legislative authority to an administrative agency.

(2) American International Health Services, Inc. v. Rhode Island Department of Health Nos. 77-3474 and 77-282 (R.I.Super.Ct. Providence County Sept. 11, 1978), cert. den., 396 A.2d 945 (R.I.1979), app.dism'd., No. 78-355-Appeal (R.I._____ 1979).

A corporation brought an action seeking judicial review of a state agency decision denying its application for a CON to construct an alcoholism detoxification/rehabilitation hospital. The state agency denied the application on the basis of the statutory CON criteria which required a showing of public need for the construction and consideration of: available alternatives, avoidance of duplication, possibility of joint services, financial feasibility, and quality.

The Court held that the statutory criteria were not unconstitutionally vague and ambiguous nor an improper delegation of legislative power to an administrative agency because the requirement that an applicant demonstrate "public need" combined with the five factors for consideration was no more vague and ambiguous than other standards of proof like the "fair preponderance of the evidence" standard.

(3) Cf. Page v. Capital Medical Center 371 So.2d 1087 (Fla.Dist.Ct.App. 1979)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to construct a new hospital. The Court held that the state statute properly established criteria by which the state agency could independently evaluate whether to issue or deny a CON because the statute required the state agency to consult with certain agencies and professional associations in matters of policy and standards for issuance of CONs, to adopt rules, regulations, and minimum standards for the issuance of CONs, and to abide by those rules, etc. in issuing CONs.

(4) Huron Valley Hospital Inc. v. Michigan State Health Facilities Commission No. 80-200-439-AA (Mich.Cir.Ct. Oakland County March 27, 1981), aff'd on other grounds, 312 N.W.2d 422 (Mich.App. 1981), app.den. No. 68442 (Mich. Mar. 11, 1982)

A hospital corporation brought an action seeking judicial review of a state agency denial of its application for a CON to construct a new hospital. The Court held that the state CON statute, which gave the state Director of Public Health and Health Facilities Commission the authority to determine need for proposed health facility construction, conversion, addition, or modernization projects, did not unconstitutionally delegate legislative authority to administrative agencies or vest unlimited discretion in the Director or the Commission because: (1) both the Commission and the Director were required to consider the enumerated statutory CON criteria; (2) the Director was required to adopt regulations concerning the issuance of CONs, gather and consider financial ability data, and seek HSA recommendations; and (3) the state plan for hospital construction and the policies and procedures for participation in federal loan programs were incorporated into the CON statute as additional standards.

(5) B.H.I., Inc. v. Connecticut Commission on Hospitals and Health Care No. 258137 (Conn.Super.Ct. Hartford - New Britain Jud.Dist. Dec. 22, 1982)

A convalescent home brought an action seeking judicial review of a Commission decision denying its application for a CON to convert into a psychiatric hospital. The state

CON statute authorized the Commission when deliberating on CON applications to consider a set of enumerated criteria (relationship to HSP/SHP, financial feasibility, quality, accessibility, cost-effectiveness, etc.) and "any other factors which the Commission deems relevant." (C.G.S. §19-73K transferred to §19a-153 (1983)). The Court held that such a delegation of discretion regarding the content of review criteria was not an unconstitutional delegation of discretionary authority to an administrative agency, nor was the statute unconstitutionally void for vagueness by virtue of the delegation because: (1) valid primary standards to govern the agency's exercise of discretion were set forth in the statute in the form of the enumerated criteria and a statement of legislative findings in effect at the time of the application, and these primary standards were followed by the agency; (2) the policies and general requirements of the CON statute could be understood by a person of common intelligence and plaintiff was aware of them; and (3) the fact that discretion has been granted to an agency does not mean that the statute is void for vagueness.

d. Unlawful Delegation of Governmental Authority to a Private, Non-Governmental Organization

(1) Simon v. Cameron 337 F.Supp. 1380 (C.D. Ca. 1970)

A convalescent hospital which had been denied a license brought an action for declaratory and injunctive relief challenging the constitutionality of the provisions of the state convalescent hospital licensure statute which required it to obtain the approval of the local and state Comprehensive Health Planning agencies as a condition of licensure. The hospital challenged the constitutionality of the requirement as an unlawful delegation of governmental authority to a private corporation (the CHP "b" agency). The Court held that there was no unlawful delegation to a private, non-governmental organization because: (1) final decision-making authority reposed in a state Health Planning Council appointed by the Governor and the Legislature, with the local agency having merely initial decision-making authority subject to appeal to the State Council; and (2) the CHP "b" agency was so closely connected with the state as to make it a public administrative body.

e. Vagueness of Particular Statutory Provisions

(1) Simon v. Cameron 337 F.Supp. 1380 (C.D. Ca. 1970)

A convalescent hospital which had been denied a license brought an action for declaratory and injunctive relief challenging the constitutionality of the provisions of the state convalescent hospital licensure statute which required it to obtain the approval of the local and state Comprehensive Health Planning agencies as a condition of licensure.

The hospital asserted that the criteria and standards for CHP approval were void for vagueness. The Court held that the statutory standard for project approval by CHP agencies --"community need and desirability"--was not vague and overbroad because assessment of need is a definite and reviewable delegation and the legislature has further guided the voluntary agencies in their determinations of need by requiring certain kinds of information of applicants which are obviously intended to be among the factors to be considered in determining need.

(2) People v. Dobbs Ferry Medical Pavilion 340 N.Y.S.2d 108 (App.Div. 1973), aff'd, 347 N.Y.S.2d 452 (Ct.App. 1973)

The State Health Department brought an action to enjoin a partnership of three physicians from operating a practice primarily devoted to the performance of abortions without obtaining a license as an "independent out-of-hospital health facility." This was a type of hospital defined in state regulations as an "institution with one or more health clinics not part of an inpatient health facility...which is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician." The Court held that the terminology used in the statute and regulation (i.e., "facility" and "clinic") were unconstitutionally vague and overbroad because they encompassed many kinds of individual, partnership, and group medical practices clearly not intended to be subject to licensing, and because the terms did not disclose whether they applied to physical, functional, or personnel resources and characteristics.

(3) American International Health Services, Inc. v. Rhode Island Department of Health Nos. 77-3474 and 77-282 (R.I.Super.Ct. Providence County Sept. 11, 1978), cert. den., 396 A.2d 945 (R.I.1979), app.dism'd., No. 78-355-Appeal (R.I.____ 1979) supra, p. 6.

(4) Greater St. Louis Health Systems Agency v. Teasdale 506 F.Supp. 23 (E.D. Mo. 1980).

An HSA and individual HSA members brought an action challenging the validity of several provisions of the state CON statute. The Court held that: (1) the provision of the statute prohibiting the use of state, federal, or local funds for "lobbying activities with the Missouri General Assembly" by HSA members or employees was so indefinite as to fail to give plaintiff HSA members fair notice of the conduct proscribed; and (2) therefore, the provision was inconsistent with the due process clause of the U.S. Constitution.

(5) Village of Herkimer v. Axelrod 451 N.Y.S.2d 303 (App. Div. 1982), aff'd on other grounds 462 N.Y.S.2d 633 (Ct. App. 1983)

A local public hospital brought an action seeking to enjoin as unconstitutional the state Commissioner of Health's proceedings to modify the hospital's operating certificate to convert it from an acute care hospital to a long-term care facility. The state health planning statute authorized the Commissioner to modify or revoke a hospital's operating certificate after considering the total number of beds necessary to meet the public need and the availability of alternatives and finding that "modifying or revoking the operating certificate of such facility would be within the public interest in order to conserve health resources by restructuring the number of beds and/or the level of services to those which are actually needed." (N.Y. Public Health Law §2806(6)(a)).

The Court upheld the Commissioner's action, holding that the statutory criteria for operating certificate modification--"public need" and "public interest"--were not unconstitutionally vague, indefinite, and subjective so as to require that they be further defined by regulation because: (1) in the context of their legislatively declared requirement that the Commissioner consult the SHPDA before acting the criteria were sufficiently definite and specific; (2) there is no constitutional requirement that the Commissioner implement the legislation through his rule-making powers rather than through enforcement on a case-by-case basis; and (3) the fact that other regulations had been promulgated concerning initial establishment and construction of hospitals did not impel adoption of corresponding regulations for certificate modification because the Commissioner could rationally conclude that a greater need existed to provide general rules notifying the industry of the standards for approval of new construction.

(6) B.H.I., Inc. v. Connecticut Commission on Hospitals and Health Care No. 258137 (Conn.Super.Ct. Hartford - New Britain Jud.Dist. Dec. 22, 1982), supra, p. 7.

f. Establishment Clause

(1) Tulsa Area Hospital Council, Inc. v. Oral Roberts University 626 P.2d 316 (Okla. 1981)

An organization of local hospitals brought an action appealing a SHPDA decision granting a CON to Oral Roberts University (ORU) to construct a new hospital in the area. The SHPDA had concluded that the project would provide a national constituency with a unique form of medical care nowhere else available called holistic medicine: scientific medicine, laying on of hands, and prayer provided together in a controlled atmosphere. The Court held, among other things, that the SHPDA did not contravene the establishment clause of the First Amendment by granting the CON because the SHPDA's decision to determine need for holistic, religious medical services independent of need for conventional health services was merely the resolution of a medical issue, and did not constitute the impermissible conferring of an advantage on ORU on religious grounds.

g. Special Legislation

(1) Commissioner of Public Health v. Bessie M. Burke Memorial Hospital 323 N.E.2d 309 (Mass. 1975)

A state agency brought an action seeking a declaratory judgment as to the constitutionality, under the Fourteenth Amendment and provisions of the state constitution prohibiting special legislation and violation of the doctrine of separation of powers, of a statute commanding the agency to issue CONs to certain projects it had previously disapproved. The Court upheld the statute, ruling that such statutes are invalid only where they do specific injury to identifiable persons, not where, as here, they may merely increase costs to the public over the long run.

(2) Paul Kimball Hospital, Inc. v. Brick Township Hospital, Inc. 432 A.2d 36 (N.J. 1981) supra, p. 6.

(3) Rush City Hospital v. Sandstone Area Hospital and Nursing Home, Inc. No. 82-398 (Minn. Sup. Ct. Nov. 24, 1982)

A competitor hospital brought an action seeking a declaratory judgment that a state statute exempting from CON a specific project planned by another hospital was unconstitutional as special legislation. In 1977 a county Board of Commissioners sold its hospital to a private non-profit corporation. As part of the sales agreement the Board endorsed a facility plan for acute and long-term care in the county which called for the designation as acute care beds of ten long-term care beds at a for-profit nursing home owned by the individual who submitted the nonprofit corporation's bid to the Board. In 1981 the state legislature passed special legislation permitting the non-profit corporation to fulfill its contract with the Board without complying with the state CON statute. The state constitution prohibited special legislation but excepted special laws which related to a single local government unit, provided that such laws not become effective until approved by the voters or the governing body of the affected unit. The Court held that the special CON exemption legislation fell within the local government unit exception because a local government unit was affected. However, it ruled that the special legislation had not yet become effective because it had not yet been approved by the local unit of government.

h. Separation of Powers

(1) Olathe Hospital Foundation v. Extendicare, Inc. 539 P.2d 1 (Kan. 1975)

Several hospitals brought an action seeking judicial review of a state agency appeals panel's final decision awarding a CON to their competitor to construct a new hospital. The state CON statute authorized the trial court, on appeal of an administrative decision on a CON application, to independently determine whether or not the applicant was entitled to a CON. The Court held that the statutory provision was void because the constitutional separation of powers doctrine limits the courts to a more circumscribed form of judicial review, i.e., the determination of whether there is substantial evidence in the record to support the administrative decision.

i. Taking for Public Use

(1) Village of Herkimer v. Axelrod 451 N.Y.S.2d 303 (App. Div. 1982), aff'd on other grounds 462 N.Y.S.2d 633 (Ct. App. 1983)

A local public hospital brought an action seeking to enjoin as unconstitutional the state Commissioner of Health's proceedings to modify the hospital's operating certificate to convert it from an acute care hospital to a long-term care facility. The state health planning statute authorized the Commissioner to modify or revoke a hospital's operating certificate after considering the total number of beds necessary to meet the public need and the availability of alternatives and finding that "modifying or revoking the operating certificate of such facility would be within the public interest in order to conserve health resources by restructuring the number of beds and/or the level of services to those which are actually needed." (N.Y. Public Health Law §2806(6)(a)). The Court held that the Commissioner's action to convert the facility from an acute care hospital to a long-term care facility was not an unconstitutional taking of property without just compensation because health facility and hospital regulation fell well within the state's police power and such a conversion was hardly the kind of destructive restriction on use that amounts to a taking.

(2) Whitehall Boca v. Dept. of Health and Rehabilitative Services 456 So.2d 928 (Fla.Dist.Ct.App. 1984)

Two nursing homes brought an action seeking judicial review of a state agency decision denying their petitions challenging the validity of the state CON regulatory review criterion on access. One of the nursing homes served only private pay patients; both had CON applications planned or pending. The state's CON "access" criterion duplicated with minor changes the CON "access" criteria in 42 C.F.R. §§123.412(a)(5), (6) and 123.413, including the provisions for considering the level of indigent care, Medicaid participation, etc., in determining accessibility. The Court held that the state access criterion did not on its face mandate the taking of private property for public use. Although in application the rule could conceivably result in the denial of an application for a certificate of need in some instances, the constitutionality of that action will be an issue reserved for the happening of that event.

j. Right to Petition Government

(1) St. Joseph's Hospital, Inc. v. Sibley No. D-12402 (Georgia Super. Ct., Fulton Cty., Aug. 17, 1984)

A hospital brought a mandamus action seeking an order directing the state CON appeals board to conduct a hearing on its CON application. The board had apparently stayed the appeals hearing indefinitely. The Court granted the hospital's petition and ordered the board to set a date certain for hearing, holding that the board's indefinite staying of the appeal was a constitutionally impermissible denial of the hospital's right of access to the courts.

INTERACTION OF FEDERAL AND STATE HEALTH PLANNING LAWS WITH OTHER LAWS

1. NHPRDA

a. Preemption

(1) NHPRDA preempts state health planning law

(A) Park East Corporation v. Califano 435 F. Supp. 46 (S.D. N.Y. 1977).

A hospital brought an action to enjoin federal and state officials from taking actions to close its facility, ostensibly for licensure and structural code deficiencies but actually, the hospital alleged, with the intention of closing the facility to reduce excess bed capacity in New York City. The Court granted plaintiff a preliminary injunction, holding that: (1) by adoption of NHPRDA Congress intended to preempt the field of health planning; and (2) NHPRDA required that before the State could close an unneeded facility the HSA and SHPDA must review the appropriateness of the facility.

(B) Cf. Save Our Samaritan v. Bay Medical Center and Bay City Samaritan Hospital No. 79-10297 (E.D.Mich. January 13, 1981)

A community organization brought an action alleging that a merger between the defendant hospitals, in connection with which the hospitals had received a CON, violated federal and state antitrust laws. Regarding the state antitrust law claim, the court observed in dicta that NHPRDA preempts inconsistent state law pursuant to the Supremacy Clause; therefore state antitrust laws could not be applied to void the merger of the two hospitals accomplished under the auspices of the Act.

(2) NHPRDA does not preempt state health planning law

(A) Fleetcrest Manor v. Commission on Hospitals and Health Care No. 032330-6 (Conn.Super.Ct. Waterbury Jud.Dist. June 15, 1981)

A rest home brought an action seeking judicial review of a state agency denial of its application for a CON to institute an alcoholism treatment program. Citing Park East Corporation v. Califano the rest home alleged that by enacting NHPRDA Congress preempted the field of health planning and rendered state CON standards inconsistent with the federal law void. The Court held that the enactment of NHPRDA did not prevent the state from conducting its own CON program because: (1) nothing in the Act expressly prohibits a state that has not signed a designation agreement with DHHS from operating a CON program; and (2), rather than following Park East, the Court would construe the state and federal laws in a manner which permitted both to function with a minimum of interference with each other.

(B) Village of Herkimer v. Axelrod 451 N.Y.S.2d 303 (App. Div. 1982), aff'd on other grounds 462 N.Y.S.2d 633 (Ct. App. 1983)

A local public hospital brought an action seeking to enjoin as unconstitutional the state Commissioner of Health's proceedings to modify the hospital's operating certificate to convert it from an acute care hospital to a long-term care facility. The state health planning statute authorized the Commissioner to modify or revoke a hospital's operating certificate after considering the total number of beds necessary to meet the public need and the availability of alternatives and finding that "modifying or revoking the operating certificate of such facility would be within the public interest in order to conserve health resources by restructuring the number of beds and/or the level of services to those which are actually needed." (N.Y. Public Health Law §2806(6)(a)).

The Court held that Section 2806(6) does not violate the supremacy clause of the U.S. Constitution because: (1) NHPRDA itself negates any Congressional intent totally to preempt the field of health planning from the states (citing 42 U.S.C.A. §300k-1(b), Public Health Service Act §1501(b) [The National Guidelines] and 42 U.S.C.A. §300m-2(b), Public Health Service Act §1523(a)(b) [the requirement that designated SHPDAs conduct appropriateness review]); and (2) NHPRDA does not expressly provide a mechanism for decertification but DHHS has indicated that the Act does not prohibit states from providing sanctions to eliminate unneeded facilities (citing the textual note accompanying the AR regulations at 44 *Fed. Reg.* 71754 [Dec. 11, 1979]).

(C) *Cf. Women's Community Health Center of Beaumont, Inc. v. Texas Health Facilities Commission* 685 F.2d 974 (5th Cir. 1982)

An abortion center brought an action in federal court seeking to enjoin state proceedings brought by THFC to bar it from operating without first obtaining a CON. The Center alleged that the state proceedings were discriminatory and exceeded the state's power to regulate abortions in violation of the constitutionally protected privacy interests of abortion recipients.

The Court dismissed the Center's action, applying the *Younger* doctrine of federal abstention to avoid interference with on-going state judicial proceedings. In so doing, the Court held that NHPRDA establishes the national health planning program as a joint federal-state effort. The state's interest in ensuring economical health care for its citizens is no less important than the federal government's interest. In recognition of the state's interest, NHPRDA gives the state government a central role in the administration of the health-care planning program within the state. In particular, NHPRDA "recognize[s] state certificate of need programs to be the basic component in an overall effort to control the unnecessary capital expenditures which contribute so greatly to the total national health bill." Health Planning and Resources Development Amendments of 1979, S.Rep.No. 96, 96th Cong., 1st Sess. 5, *reprinted in* (1979) U.S. Code Cong. & Ad.News 1306, 1310. The Court also held that if a state wishes to continue receiving grants under the many programs incorporated in the Public Health Service Act, 42 U.S.C.A. §§210 to 300z-10 (West 1974 & Supp. 1982), then it must comply with the requirements of the Federal Act, citing 42 U.S.C.A. §300m(d)(2) (West Supp. 1982).

(D) *Wisconsin Hospital Association v. State Department of Health et. al.* No. 82-CV-2653 (Wisc.Cir.Ct., Dane Cty., Mar. 8, 1983)

A hospital association brought an action seeking among other things a declaratory judgement that the state's statutory CON moratorium conflicted with NHPRDA and thus was unconstitutional under the Supremacy Clause. The Court granted summary judgement for the state on this issue, ruling that the moratorium did not violate the Supremacy Clause by conflicting with NHPRDA because: (1) NHPRDA is not compulsory on the state and a state is not obliged to conform its health policy laws and regulations to NHPRDA; and (2) as a consequence, the differences between Wisconsin's law and the federal law are not important for purposes of determining whether Wisconsin's moratorium unconstitutionally conflicts with federal law. The court ruled that if the state agency, which is obliged to carry out the directives of the state legislature and administer the moratorium, fails to meet the federal criteria for a CON program, then the Secretary of DHHS may act to reduce and finally eliminate grants to the state agency under 42 U.S.C. §300m(d)(2). But that is the extent of the penalties that may be imposed, and DHHS may not compel Wisconsin to adopt a CON program that meets federal guidelines. Thus, if DHHS declines to determine that Wisconsin is not in compliance the Court cannot determine otherwise.

(E) St. Joseph's Hill Infirmary, Inc. v. Mandl 682 S.W.2d 821 (Mo. App. 1984)

A nursing home brought an action seeking judicial review of a SHPDA decision granting a CON to its competitor to construct a nursing home. The state CON statute required the SHPDA to conduct a hearing on an application at the request of any "affected person" (defined in the statute as the applicant, the HSA, health care facilities in the area, and the public) and gave the applicant and the HSA the right to seek judicial review. The nursing home argued that it was the intent of the state legislature in adopting the CON statute to provide whatever was required by NHPRDA, and argued further that NHPRDA regulations granted competitors standing to appeal CON decisions. In the course of holding that the nursing home lacked standing to seek judicial review, the Court observed that the state CON law was enacted in response to NHPRDA but refused to conclude that the state law automatically encompassed whatever might be included in NHPRDA regulations because: (a) the state law does not clearly support such a interpretation; and (b) the federal regulations are not mandatory upon the states as they are subject to waiver by the Secretary or subsequent amendment. The Court also observed that NHPRDA requires that a designated state agency have the authority under state law to administer an acceptable certificate of need program and that NHPRDA is not technically mandatory but establishes an optional program which a state must implement in order to received federal funds allocated by the Act.

(F) Cf. East Tennessee Health Improvement Council, Inc. v. Tennessee Health Facilities Commission 626 S.W.2d 272 (Tenn.Ct.App. 1981)

An HSA brought an action seeking judicial review of a state agency decision granting a CON, over the HSA's recommendation to deny, to an existing hospital to add beds. The HSA alleged NHPRDA granted it standing, citing 42 U.S.C. §300n-1(b)(12)(E). The Court held that THFC had not included the cited NHPRDA provisions in its procedures and NHPRDA did not appear to be self-executing.

(G) Cf. Princeton Community Hosp. v. State Health Planning 328 S.E.2d 164 (W.Va. 1985)

Two hospitals brought consolidated actions seeking judicial review of state agency decisions denying their applications for bed addition/expansion CONs. In the course of upholding the state agency decisions, the Court observed that state NHPRDA participation was not required, although states not choosing to do so faced significant losses in federal funding of health-related programs.

b. Enforcement of NHPRDA Compliance Requirements

(1) NHPRDA requirements enforceable

(A) Cf. New York City Coalition for Community Health v. Lindsay 362 F.Supp. 434 (S.D.N.Y. 1973)

Several community groups, a coalition of organizations that had formerly been experimental district boards advising a 314(b) CHP agency, and various individuals brought an action against the local 314(b) agency alleging violations of the Comprehensive Health Planning and Public Health Services Amendments of 1966 (P.L. 89-749), and its amendments in the composition and selection of the agency's governing board. The Court held that the federal statute contained an implied civil remedy for its beneficiaries because the statute was adopted to benefit a particular class of persons and in such circumstances a remedy for violation less drastic than termination of federal funding should be implied.

(B) Park East Corporation v. Califano 435 F.Supp. 46 (S.D.N.Y. 1977)

A hospital brought an action to enjoin federal and state officials from taking actions to close its facility, ostensibly for licensure and structural code deficiencies but actually, the hospital alleged, with the intention of closing its facility to reduce excess bed capacity. The hospital alleged that the officials were violating certain procedural provisions of NHPRDA. The Court first held that the NHPRDA preempted the field of health planning and then held that, given Congress' clear intent to have all health planning realized pursuant to NHPRDA, a cause of action on behalf of a party aggrieved by reason of non-compliance with the Act should be implied.

(C) Schwartzberg v. Califano 480 F.Supp. 549 (S.D.N.Y. 1979)

Nursing home operators brought an action to enjoin various federal and state officials from terminating the Provider Agreements which qualified them to receive Medicare and Medicaid funding. They alleged that the terminations were undertaken for the purpose of closing their facilities in order to eliminate excess bed capacity, and they alleged that such an action could not be undertaken without compliance with certain procedural requirements of NHPRDA. The Court, citing Park East Corporation v. Califano, held that NHPRDA contained an implied cause of action on behalf of the plaintiffs.

(D) Greater St. Louis Health Systems Agency v. Teasdale 506 F.Supp. 23 (E.D.Mo. 1980)

An HSA and individual HSA members brought an action seeking declaratory and injunctive relief and alleging that various provisions of its state's certificate of need statute were inconsistent with NHPRDA and implementing regulations and therefore void under the Supremacy Clause. They raised this assertion as to provisions of the state CON statute which: (1) defined "health systems agencies" for state law purposes in such a way that some federally-designated health systems agencies would lose their right, granted under state law as required by NHPRDA regulations, to an administrative appeal of a state CON decision inconsistent with their recommendation and to a copy of the final state agency decision [see 42 C.F.R. §123.407(a)(9), (10) (1979)]; (2) required selection of HSA governing body members by local government officials; (3) provided that it be a misdemeanor for HSA members or employees to use any state, federal, or local funds for lobbying activities with the state legislature; and (4) provided for a state-level CON program inconsistent with NHPRDA in several ways.

The Court held that: (1) NHPRDA is not a mandatory regulation nor an exercise of Congressional power under the Commerce Clause. Instead it is an exercise of the spending power. (2) The HSA only had standing to assert its 1st, 2nd, and 3rd claims because only those claims related to sections of the state CON statute which affected the HSA. (3) The state CON statute's restrictive definition of "health systems agency" must be declared invalid for its inconsistency with federal law. The Court observed that the HSAs obviously have a much closer appreciation of the health care needs of an area than does a state agency, and the requirement that an HSA be allowed the right to appeal a state agency decision conflicting with its recommendation is a reasonable one, and one that helps to insure that CONs will be granted or denied only after full weight has been given to the views of the local agencies, which are presumably most familiar with the needs of their areas. (4) The state CON statute's governing body selection process conflicted impermissibly with NHPRDA and therefore must fall, because it did not provide the opportunity for the broad participation in the selection process by the residents of the health service area of the agency which is required by NHPRDA, since, although it did not preclude some degree of participation by area residents, it failed to assure that area residents' views would be given any consideration. (5) The state CON statute's lobbying ban, while broader than that in NHPRDA, did not thwart the federal scheme and consequently was not invalid because HSAs are not required to attempt to influence the passage or defeat of legislation in order to fully satisfy their required functions under NHPRDA.

(E) Alameda-Contra Costa Health Systems Agency v. Office of Statewide Health Planning and Development No. 817529 (Calif. Super. Ct., San Francisco Cty. Sept. 5, 1984)

An HSA brought an action seeking judicial review of SHPDA decisions awarding CONs to six competing CON applicants for new hospital construction/modernization. The HSA had recommended denial of all six applications in late 1983. Following an HSA request, the SHPDA briefly commenced and then recessed hearings on the applications. In late 1983 and early 1984 the state issued CONs to each of the applicants without adopting formal findings or submitting statements of reasons for its decisions to the HSA. The HSA sought relief in the form of, among other things, a court order revoking the CONs and compelling the SHPDA to conduct hearings on the applications, adopt findings, and provide a statement of reasons to the HSA.

The Court ruled for the HSA, ordering the SHPDA to revoke the CONs and to conduct a hearing, adopt findings, and provide a statement of reasons in accordance with the requirements of NHPRDA and implementing regulations. It held that: (1) Although a state's participation under NHPRDA is optional, once a state elects to participate, as California has done, it is obliged to comply with the requirements of NHPRDA and implementing regulations. The Court cited Greater St. Louis HSA v. Teasdale for this proposition. (2) The CONs were issued in violation of federal law in that the state improperly discontinued the hearing and issued CONs without completing the hearing as required by 42 C.F.R. §123.410(a)(8) and without making the necessary findings, statement of reasons, and findings on access required by 42 C.F.R. §123.410(a)(6),(10), 123.413, and 42 U.S.C. §300m-2(c). The Court rejected the state's argument that the provisions of the Continuing Resolution under which Congress had appropriated funds for health planning eliminated the mandatory compliance requirements of NHPRDA. The Continuing Resolution in effect at the time of the Court's decision incorporated language providing that: "[N]o penalty shall be applied nor any State or agency agreement terminated pursuant to sections 1512, 1515 or 1521 of the Public Health Service Act..." (Continuing Appropriations 1984, P.L.98-151, §101(c), 97 Stat. 972 (1983)). The Court held that this language forbade DHHS from applying a statutory penalty or terminating a designation agreement because of a state's failure to comply but did not eliminate the compliance requirements, authorize their disregard, or prevent the Court from ordering the state to comply.

(F) Cf. In re HCA Health Services of Wyoming, Inc. 689 P.2d 108 (Wyo. 1984), infra p. 46.

(G) Roman Catholic Diocese of Albany v. New York State Dept. of Health 490 N.Y.S.2d 636 (App.Div. 1985)

Religious organizations and individual health care consumers brought an action seeking judicial review of a state agency decision granting a CON to a birth control clinic to add abortion services. The Court struck down the state agency decision, holding among other things that the petitioners had the right to seek judicial review of the state agency's determination under NHPRDA and its companion regulations because: (1) A State's adherence to a CON program is a condition of receiving federal financial assistance under NHPRDA; (2) New York has legislatively opted to participate in the federal program; (3) having opted to participate in and receive the financial benefit of the CON program under NHPRDA, New York is bound by the provisions thereof insofar as they mandate access to an appropriate state court for the purpose of challenging a state agency decision; (4) NHPRDA grants the right to judicial review to "persons adversely affected"; (5) federal regulations in effect at the time of the initiation of this proceeding defined the foregoing phrase to include any person residing within the geographical area to be served under the application, regularly using health care services in the area, or participating in the proceeding before the state agency [42 C.F.R. §123.401, 410(14) (1981) (amended 1985)]; (6) the regulations are controlling over any state restriction on access to the courts by persons having a federal right to review of state agency CON decisions; and (7) each of the petitioners was either a resident of the geographical area affected by the proposed project or participated personally or through a representative in the administrative proceeding. Therefore, each has a federally-created right to seek judicial review and each has statutory standing.

The Court rejected the state agency's argument that petitioners' NHPRDA right to judicial review was eliminated by federal CON regulation amendments adopted January 14, 1985 during the pendency of these proceedings which deleted the regulatory definition of "affected persons." It held that the regulatory amendment should not be applied to undo standing already validly acquired because there was nothing to indicate that the deletion was intended to restrict standing to obtain judicial review of CON decisions or that it was designed to apply retroactively to already pending judicial review proceedings in which a party had valid standing when the proceeding was commenced. The Court rejected the state agency's contention that Congress lacked the constitutional right to enlarge the jurisdiction of New York courts by conferring standing where it would not exist under state law, holding that once a justiciable controversy exists, as here, standing is a question within the constitutional power of Congress to statutorily determine.

(2) NHPRDA requirements not enforceable

(A) Metropolitan Ambulance Service, Inc. v. Lexington-Fayette Urban County Government No. 79-3430 (Sixth Cir. Dec. 17, 1980)

An ambulance service which held a CON to provide "non-urgent" ambulance services brought an action to enjoin defendant, which held a CON to provide "urgent" ambulance services in the area, from providing "non-urgent" services. The Court held that NHPRDA did not contain an implied cause of action for the benefit of the ambulance service because it was not a member of a special class the NHPRDA was intended to protect.

(B) Munchak v. HSA of Northeast Pa., Inc. No. 80-0752 (M.D. Pa. Dec. 1, 1980)

Plaintiff brought an action seeking to enjoin the HSA from undertaking various actions in connection with its review of a proposed merger of two hospitals. The plaintiff alleged that the HSA violated NHPRDA by failing to provide proper notice of public hearings, using federal funds for lobbying, and having an alleged conflict of interest. The Court held that NHPRDA contained no implied cause of action on behalf of plaintiff to remedy alleged violations by the HSA because: (1) NHPRDA was adopted to benefit all citizens (not just a special class to which the plaintiff belonged); (2) the legislative history and statutory scheme indicated judicial review was appropriate only when a final agency action had been taken (and then only resort to state court was contemplated); and (3) the issues could be better resolved under state law and procedures.

(C) Luzerne County Medical Society v. Harris No. 78-1181
(M.D.Pa. June 13, 1980)

A medical society brought an action seeking declaratory and injunctive relief to stop the Secretary of HHS and state officials from approving an extension of time to secure financing for, and an increase in the cost of, a project previously approved under Section 1122 to construct a hospital. The plaintiff alleged that the DPA violated NHPRDA when it recommended approval of the project for reimbursement under Section 1122 by failing to provide the appropriate HSA with a detailed statement of reasons for the inconsistency between its decision and the HSP/AIP. (See Section 1523(c), 42 U.S.C.A. §300m-2(c)) The Court held that, assuming the DPA violated NHPRDA, NHPRDA contained no implied cause of action on behalf of the medical society to remedy the violation because: (1) NHPRDA was not enacted for the special benefit of a class of persons to which the plaintiff belonged; (2) neither the legislative history nor the overall statutory scheme indicated a cause of action should be implied; and (3) the resolution of the issue of inconsistency between the 1122 decision and the HSP/AIP would be better left to state officials.

(D) Community Psychiatric Centers of Oregon, Inc. v. Grant
664 F.2d 1148 (Ninth Cir. 1981), rev'g, No. 79-782
(D.Ore. Order May 22, 1980, Opinion July 8, 1980)

A psychiatric center brought an action seeking to compel the Oregon SHPDA to require its competitor to undergo CON review of its newly established acute inpatient psychiatric care unit. The District Court concluded that NHPRDA contained an implied cause of action for benefit of the plaintiff, and reached the merits on the issue of whether the competitor's project was covered under the state CON statute. The Court of Appeals reversed, holding that NHPRDA contained no implied cause of action in favor of competing providers because: (1) NHPRDA cannot be said to have been adopted for the especial benefit of providers (the class of which plaintiff is a member), and (2) although Congress in adopting NHPRDA valued provider participation in health planning NHPRDA was partly designed to counteract the disproportionate influence of providers in health planning and it would be surprising if Congress meant to accomplish this aim by giving providers a cause of action under NHPRDA.

(E) Park Community Hospital, Inc. v. Comprehensive Health Planning of Southeastern Michigan No. 78-72259
(E.D.Mich. June 22, 1979), aff'd, 645 F.2d 10 (6th Cir. 1981)

A hospital sued an HSA for money damages for failure to review in a timely manner its revised application for HUD Section 242 hospital mortgage insurance, claiming that the

HSA had an obligation to undertake such a timely review arising out of NHPRDA. The Court held that, even assuming the HSA violated its statutory duties, NHPRDA should not be interpreted to create an implied remedy of money damages because: (1) such a remedy would be inconsistent with the underlying purposes of NHPRDA, and (2) there is no apparent source of funds from which such a judgment could be collected if obtained since under NHPRDA HSAs must be private, non-profit corporations financed by federal funds.

(F) Cf. Hicks, et al. v. Southern Maryland Health Systems Agency No. R-80-2980 (U.S.D.C., D.Md. March 8, 1983), infra p. 52.

c. NHPRDA and Antitrust Laws

(1) NHPRDA and Federal Antitrust Laws

(A) NHPRDA implicitly repeals federal antitrust laws

(i) Save Our Samaritan v. Bay Medical Center and Bay City Samaritan Hospital No. 79-10297 (E.D.Mich. Jan. 13, 1981)

Opponents of a proposed merger of two hospitals brought an action alleging that the merger was in violation of federal antitrust laws. The merger was subject to review under the state CON statute and it had been approved by the state agency. Citing the trial court opinions in Huron Valley Hospital, Inc. v. City of Pontiac and National Gerimedical, the Court held that NHPRDA impliedly repealed the federal antitrust laws as they related to the facts involved in the case because NHPRDA, as amended, contained language expressly recognizing that competitive market forces do not satisfactorily allocate the supply of inpatient and other institutional health services, and NHPRDA directed the federal health systems agencies and state agencies to make an appropriate allocations of those services themselves.

(ii) Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield of South Carolina, Inc. and Palmetto-Lowcountry Health Systems Agency C/A No. 81-1639-1 (D.S.C. Nov. 2, 1982); 1983-2 Trade Cas. (CCH) ¶65,674

Several physician groups who performed CT scanning in non-institutional settings brought an action against BC/BS and a HSA alleging a conspiracy to exclude them from the market in violation of federal and state antitrust statutes. They asked for damages and injunctive relief. Since 1977, BC/BS had denied reimbursement for CT scanning not operated by a hospital nor approved by a health planning agency. In 1979 an HSA study of CT scanning recommended that scanners be located only in hospitals and that all third-party payors deny reimbursement for scans performed by CT scanners for which no CON had been obtained.

The Court granted a summary judgement for the HSA, holding that it was exempt or immune from antitrust liability under several alternate grounds, including that the HSA was immune from antitrust liability because: (1) NHPRDA "impliedly immunizes" mandated planning activities; and (2) the CT study was such an activity since it was undertaken to comply with NHPRDA [see Public Health Service Act §1513(b)(2) which requires HSAs to give "appropriate consideration" to the National Guidelines for Health Planning and to adopt an HSP which "takes into account" the health resources supply and distribution standards in the Guidelines - Ed.] and to comply with the regulatory requirement that the HSA analyze the needs and conditions in its health service area and apply the National Guidelines for Health Planning, including the guidelines for CT scanners, in the development of its HSP (42 CFR §121.5 (1978)). As authority for its holding the Court cited fn. 18 of the Supreme Court opinion in National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City in which the Supreme Court indicated that some planning activities "necessary to make the Act work" might be capable of gaining implied immunity.

(B) NHPRDA does not implicitly repeal federal antitrust laws

(i) National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City 452 U.S. 378 (1981)

A corporation proposing to construct a new hospital brought an action against the local and national Blue Cross Associations alleging that the refusal of Blue Cross to accept the new hospital as a participating member in its health insurance plan violated the federal antitrust laws.

There was no CON statute or Section 1122 review program in the state. Blue Cross had adopted a policy of denying a participating hospital agreement to a new hospital unless it had been reviewed and approved by the regional planning agency, in this case Mid-America HSA (MAHSA). MAHSA had publicly announced that it would not approve any new acute care beds in the area. As a result, National Gerimedical did not submit its construction plans to MAHSA. When it applied for a participating hospital agreement Blue Cross turned it down. Blue Cross sought to defend its action in court in part by claiming that NHPRDA "impliedly repealed" the federal antitrust laws so that Blue Cross' refusal to deal with National Gerimedical was immunized from antitrust liability.

[The federal courts have ruled that when certain activities, otherwise violative of the antitrust laws, are necessary to effectuate the intent of another, non-antitrust federal statute, the conflict between the two legal regimens will be resolved by granting immunity from antitrust liability to the activities in question. Such a "repeal" of the antitrust laws is disfavored by the courts and is justified only when the other statute is "clearly repugnant" to the antitrust laws - Ed.]

The Supreme Court unanimously held that the action of Blue Cross was not immune from antitrust liability on the basis of an implied repeal because: (1) Congressional intent to repeal the antitrust laws with regard to Blue Cross' activity, which the Court characterized as "private enforcement" of the HSA's advisory decision, was not clear. (Congress contemplated, of course, that such decisions would be enforced by SHPDAs through CON statutes.) The Court found no reason to believe that Congress specifically contemplated such enforcement by private insurance providers, let alone intended to rely on such actions to put teeth into the noncompulsory local planning process; (2) intent to repeal the antitrust laws is much clearer when a regulatory agency has been empowered to authorize or require the type of conduct under antitrust challenge. In those circumstances the party seeking to employ the implied repeal defense may be subject to conflicting, specific commands from the regulatory agency and antitrust laws. There was no such direct conflict in this case; and (3) there is no "blanket exemption" from the antitrust laws for "all private conduct undertaken in response to the health planning process."

(ii) Huron Valley Hospital, Inc. v. City of Pontiac 666 F.2d 1029 (Sixth Cir. 1981), vacating, 466 F.Supp. 1301 (D.Mich. 1979) ("Huron v. Pontiac I")

A corporation formed to build a new hospital in Pontiac brought an action against the existing public hospital in Pontiac, the city, the HSA, and various state and federal officials alleging a conspiracy to exclude it from the market of providing hospital facilities and services in violation of federal antitrust laws, carried out in the context of opposition to the corporation's CON application. The corporation's application for a CON to construct the proposed hospital was opposed by the existing hospital, recommended for denial by the HSA, and denied by the state agency; several months later the existing hospital's application for a CON to renovate its facilities was approved. The District Court held that the alleged conspiracy was exempt from antitrust liability by virtue of an implied blanket repeal of the antitrust laws by NHPRDA. The Court of Appeals reversed, and, citing National Gerimedical, held that the alleged conspiracy was not immunized under the implied repeal doctrine because NHPRDA was not so incompatible with antitrust concerns as to create a pervasive repeal of the antitrust laws as applied to every action taken in response to the healthcare planning process.

(iii) In re American Medical International, Inc. Dkt. No. 9158 (Federal Trade Commission, initial decision July 27, 1983)

The Federal Trade Commission commenced an administrative proceeding against AMI alleging that it had attempted to monopolize and had monopolized the general acute care hospital market in San Luis Obispo County, California when it acquired its third hospital in the five-hospital county. AMI planned to merge the acquired facility with one of its previously-acquired facilities. The complaint sought divestiture of the acquired hospital and certain restraints on future hospital acquisitions by AMI. AMI alleged, among other things, that the challenged acquisition should be immunized from scrutiny under the federal antitrust laws because the acquisition and planned merger were intended and reasonably calculated to advance the goal of hospital mergers to reduce excess capacity recommended in the local HSA's HSP, and immunity under the implied repeal doctrine was therefore necessary to make NHPRDA's purpose of HSP implementation through voluntary initiative work. The Administrative Law Judge rejected this argument, ruling that: (1) Direct conflict between NHPRDA and antitrust scrutiny of the acquisition giving rise to a "clear repugnancy" between the two regulatory schemes is necessary for an implied repeal under the rule of National Gerimedical; (2) no such direct conflict was present in this proceeding because neither state nor federal law required or provided for issuance of a CON for hospital acquisitions, the HSA did not review or approve the acquisition nor was it consulted in connection with the acquisition, and nothing in NHPRDA required or authorized AMI to acquire the hospital. Thus, application of the antitrust laws to AMI's acquisition would not frustrate a particular provision of NHPRDA nor create a conflict with the orders of any regulatory body. The ALJ also noted that any reliance AMI might place on Fn. 18 of National Gerimedical (in which the Supreme Court indicated that its holding would not foreclose future claims of antitrust immunity in other factual contexts, such as where an HSA had expressly advocated a form of cost-saving cooperation among providers) would be misplaced since no such expressly advocated form of cooperation was present in this case; and (3) AMI's acquisition was entirely profit-motivated and only incidentally may have been consistent to some extent with the HSA's goals.

(iv) North Carolina v. P.I.A. Asheville, Inc. 740 F.2d 274 (4th Cir. 1984)

A state Attorney-General brought an action against a psychiatric hospital corporation alleging that it created a monopoly in violation of federal and state antitrust laws when it acquired the second of the two psychiatric hospitals in a city. It had earlier acquired the first hospital. At the time of the acquisitions in 1980-81, the state CON law provided for coverage of all acquisitions of existing health facilities, and P.I.A. had obtained a CON for each acquisition. The second hospital acquisition did not involve a change in bed capacity or services. The District Court granted summary judgment for P.I.A., holding in the alternative that the acquisition was immune from antitrust scrutiny under the implied repeal doctrine and that the acquisition was exempt under the "state action" doctrine. The Court of Appeals initially affirmed the District Court on implied repeal, concluding that to allow the antitrust laws to strike down transactions approved by state health planning agencies would unduly interfere with the operation of NHPRDA and subject participants in the CON process to conflicting standards. [722 F.2d 59 (4th Cir. 1983)].

On rehearing the Court of Appeals reversed the District Court on both the state action and implied repeal grounds. Regarding implied repeal, the Court held that NHPRDA did not impliedly repeal the application of federal antitrust laws to the acquisition of the second hospital because: (1) There are two independent tests for implied repeal: affirmative showing of Congressional intent to repeal the antitrust laws by another non-antitrust federal statute and irreconcilable conflict or clear repugnancy between the antitrust laws and another non-antitrust federal statute. (2) There was no affirmative showing of Congressional intent in NHPRDA to repeal the antitrust laws' coverage of the second acquisition since: (a) The finding of fact in NHPRDA that recognized the shortcomings of competition in improving health services provision (42 U.S.C. §300k-2(b)(1) was not tantamount to a finding that Congress intended to bar the use of the most powerful pro-competitive laws, the federal antitrust laws, for all NHPRDA-covered activity; (b) NHPRDA does not require state CON programs to cover acquisitions such as P.I.A.'s that do not involve changes in bed capacity or services and if Congress did not intend for CON review boards to approve such acquisitions it follows that Congress cannot have meant for CON review to supplant antitrust review of such acquisitions; (c) the legislative history of the National Health Planning and Resources Development of 1974 is totally silent on the subject of intent to repeal the antitrust laws and the 1979 NHPRDA amendments manifest an intent to provide for regulation to supplement but not to supplant competition; (d) convincing public policy reasons militate against a finding of implied immunity in this case, in that the antitrust laws are a fundamental national economic policy and NHPRDA's goal of making better health care more widely available would not be harmed by antitrust review; (e) Congressional intent to repeal is indicated in part by whether the non-antitrust regulatory scheme provides for remedies comparable to those available under the Sherman or Clayton Acts and: (i) the remedies of fines and injunctive relief for violation of the state CON statute are not comparable to the treble damages provision of the Sherman Act available for a violation such as that alleged in this case; and (ii) the state CON statute does not provide remedies for post-acquisition monopolistic conduct; and (f) a finding of implied immunity may be made without clear repugnancy if the regulation in question is "pervasive." NHPRDA and the state CON statute in this case do not satisfy the various tests of regulatory "pervasiveness" announced by the courts since: (i) NHPRDA's legislative history does not indicate an intent to subordinate antitrust to regulatory policy or to approve monopolies; (ii) the CON system has no provision for remedial relief approaching that provided by the antitrust laws, nor does it impose a duty on anyone to enforce an antitrust standard through the regulatory program, nor does it authorize anyone to command anticompetitive conduct; and (iii) there are significant inconsistencies between the goals of the state CON law and the post-acquisition raising of rates by P.I.A. (3) There is no irreconcilable conflict or plain repugnancy between the antitrust laws and NHPRDA since the two statutes are capable of co-existence in that receipt of a certificate of need for an acquisition and review of the acquisition under the standards of the federal antitrust laws could have been two independent steps in a process toward a successful acquisition.

(C) Other NHPRDA/federal antitrust law cases

(i) Cf. Denver v. Santa Barbara Community Dialysis Center 1981-1 TRADE REG.REP. (CCH) Trade Cas. ¶53,946 (C.D. Ca. 1981)

Two nephrologists brought an action against a hospital, an outpatient dialysis clinic (which owned or allegedly controlled all of the existing dialysis stations in the area), and others alleging violations of federal antitrust laws by, generally, conspiracy to monopolize or attempted monopolization of the provision of outpatient dialysis services in Santa Barbara County. CON applications filed by plaintiffs, defendant clinic, and others to construct additional outpatient dialysis facilities in the county were pending before the HSA. The Court held that under the doctrine of primary jurisdiction the antitrust action should be stayed pending the administrative decision on the CON applications because: (1) the case involved the issue of implied repeal of the antitrust laws by NHPRDA and the agency adjudication would be a material aid in ultimately resolving that issue, and (2) since the issue of whether defendants would acquire a monopoly was within the jurisdiction of the health planning agencies, their decision would affect the necessity for any judicial intervention at all.

(ii) Cf. Hospital Building Company v. Trustees of the Rex Hospital 691 F.2d 678 (4th Cir. 1982)

A newly-built hospital (HBC) brought an action against a competitor (Rex), and its administrator and trustees alleging that they conspired with the director of the local CHP agency, an Assistant Attorney General assigned to the state CON agency, and the state Blue Cross/Blue Shield plans to exclude HBC from the local market for inpatient services and to monopolize the market by, among other things, preventing HBC from acquiring a CON or delaying the granting of the CON.

In 1969 Rex and Wake Memorial were the leading hospitals in Raleigh, North Carolina; HBC operated a smaller facility. In 1969 Rex, Wake, the local CHP, and others organized a Joint Long Range Hospital Planning Committee to study the need for inpatient services in the area. It concluded that Rex and Wake should undergo major expansion and HBC lesser expansion. In 1971 the state adopted a CON statute and HBC applied for a CON to replace and expand its facility. The local CHP agency recommended denial and, following approval of the application by the state, brought an unsuccessful administrative appeal and action for judicial review. That action was rendered moot by the decision of the state Supreme Court in 1973 striking down as unconstitutional the state CON statute. (In Re Certificate of Need for Aston Park Hospital.) However, HBC's hospital was not built until 1977 because of rising interest rates, delay created by the need to obtain 1122 approval (the state entered into a 1122 agreement in 1973), and an allegedly discriminatory BC/BS reimbursement policy.

The case came before the Fourth Circuit after a $7.3M jury verdict for HBC. The Court reversed and remanded for a new trial, making the following rulings: (1) The trial court had instructed the jury that Rex's actions in forming and participating in the Joint Long-Range Planning Committee were to be analyzed as per se antitrust violations. The Fourth Circuit reversed, holding that Rex's conduct should be analyzed under a "narrow rule of reason" under which "planning activities of private health services providers are not 'unreasonable' restraints under Section 1 [of the Sherman Act] if undertaken in good faith and if their actual and intended effects lay within those envisioned by specific federal legislation in place at the time of the challenged activities as desirable consequences of such planning activities." The critical question in application of the rule, said the Fourth Circuit, is whether the duplication of resources sought to be avoided by the planning activities is in fact needless duplication - a determination to be gauged by the fact-finder in relation to the health care needs of the consumer public in the market area at the time in question. The Court indicated that this special rule of reason arose out of federal health planning laws [the statutes in effect at the time of the conduct complained of in this action included the various statutes adopting the RMP and CHP programs] which were in limited derogation of the normal operation of the antitrust laws. It also announced that the special rule of reason would be an affirmative defense to an antitrust action. (2) The Court also ruled that "intent to avoid needless duplication of health care resources" could be raised by Rex as a defense to the "attempted monopolization" and "conspiracy to monopolize" causes of action under Section 2 of the Sherman Act. (3) HBC's alleged damages were lost revenues occasioned by delay of construction of its facility. The Court held that HBC's damages proximately caused by Rex's actions could include revenues lost due to the delay directly and immediately caused by increased interest rates and the need for HBC to obtain 1122 approval, because an obvious motivation for defendants in seeking to delay HBC's CON would be the hope that during the interim unforeseen occurrences such as interest rate increases and new regulatory requirements would intervene to prevent realization of the project.

(iii) DeSoto Medical Center, Inc. v. Methodist Hospitals of Memphis 604 F.Supp. 307 (S.D. Miss. 1985), infra p. 64.

(2) NHPRDA and state antitrust laws

(A) Save Our Samaritan v. Bay Medical Center and Bay City Samaritan Hospital No. 79-10297 (E.D. Mich. January 13, 1981)

A community organization brought an action alleging that a merger between two hospitals, in connection with which the hospitals had received a CON, violated federal and state antitrust laws. Regarding the state antitrust law claim, the Court observed in dicta that NHPRDA preempts inconsistent state law pursuant to the Supremacy Clause; therefore state antitrust laws could not be applied to void the merger of the two hospitals accomplished under the auspices of NHPRDA.

d. NHPRDA/Section 1122 and National Environmental Protection Statutes

(1) National Association for Advancement of Colored People v. Medical Center, Inc. 584 F.2d 619 (3rd Cir. 1978), aff'g, 436 F.Supp. 1194 (D.Del. 1977)

An organization representing minority groups brought an action seeking a declaratory judgment that the Secretary of HEW erred in approving for reimbursement, under

Section 1122, Wilmington Medical Center's relocation project without first filing an environmental impact statement (EIS). Under Section 1122 the Secretary of HEW lacks the discretionary power to override the decision of the DPA once that agency has approved, by proper procedure, a capital expenditure proposal. The Court held that HEW was not required to file an EIS by the National Environmental Policy Act (NEPA) because the Secretary's "merely ministerial" approval of Wilmington Medical Center's project did not constitute a "major federal action significantly affecting the quality of the human environment" (the prerequisite for application of NEPA's EIS requirement) since HEW did not directly finance or plan and promote the project, HEW was not empowered to consider environmental effects in its review of the DPA's favorable recommendation, and there was no nexus between the federal 1122 approval of the project and the project's impact on the environment.

e. NHPRDA and State Hospital Revenue Bond Authorizing Statutes

(1) In re Validation of $15,000,000 Hospital Revenue Bonds (Methodist Hospital Project) 361 So.2d 44 (Miss. 1978)

A taxpayer group brought an action seeking judicial review of the validity of a local government issuance of hospital revenue bonds pursuant to a state hospital revenue bond authorizing statute. The Court held that the plaintiff's objection to the bond issuance as violative of the spirit and letter of NHPRDA because the proceeds would be used to construct a new hospital in an inaccessible location was collateral to the question of the validity of the bond issuance and therefore properly overruled.

f. NHPRDA and State Health Facility Rate Regulation Statute

(1) Health Care Plan of New Jersey, Inc. v. Schweiker 553 F.Supp. 440 (D.N.J. 1982)

An HMO brought an action seeking, among other things, a court order declaring the state DRG-based hospital rate regulation statute void because in conflict with the federal HMO Act and NHPRDA and therefore preempted under the Supremacy Clause. The DRG system made illegal the HMO's *per diem* contracts for inpatient services at hospitals, which the HMO alleged were necessary to permit it to meet federal HMO qualification requirements. The Court held that: (1) the DRG system was not expressly or impliedly preempted by the HMO Act (*See* 42 U.S.C.A. §300e-10 (1976)); and (2) while the National Guidelines in NHPRDA mention HMO development as a priority (Public Health Service Act §1502(a)(3), 42 U.S.C.A. §300k-2(a)(3)) and Section 1532 of the Act lists the special needs of HMOs as a consideration in CON, PUFF, AR, etc. (42 U.S.C.A. §300n-1(c)(8)), the provisions appear to create no warrant for invalidation of the DRG system or state law.

2. State Health Planning Laws

a. State Health Planning and Rate Regulation Laws

(1) Mercy Hospital v. Rate Setting Commission 407 N.E.2d 337 (Mass. 1980)

A hospital brought an action seeking judicial review of a hospital rate-setting commission order denying it approval for new charges for a CT scanner which, the commission had determined, the hospital had acquired without obtaining the requisite CON. The Court held that the commission had authority to issue such a denial, because it had general power to set forth substantive standards for reviewing applications for new charges, and common sense indicated that the general power authorized a regulation providing for denial of charges arising through the provision of presumptively illegal services. The Court also ruled that in adopting the regulation the rate-setting commission did not improperly exceed its jurisdiction by behaving as an "enforcement agency" for the CON statute because: (1) the statutes governing rate-setting and CON have the common goal of controlling costs, and (2) occasional, incidental denial of approval for charges associated with projects instituted without a CON will not usurp the SHPDA's CON functions.

b. State Health Planning and Facility Licensure Laws

(1) New Jersey Association of Health Care Facilities v. Finley 415 A.2d 1147 (N.J. 1980), aff'g, 402 A.2d 246 (N.J.Super.Ct.App.Div. 1979), cert.den., 449 U.S. 944 (1981)

A nursing home association brought an action challenging a state regulation which required nursing homes to make available a reasonable number of their beds to indigent persons as a condition of licensure. The association argued that the State Health Care Facilities Act established two separate and distinct regulatory mechanisms, licensure and CON, with regulation of quality of care assigned exclusively to licensure and regulation of the quantity of care and access issues assigned exclusively to CON. Thus, they argued, the licensure regulation was beyond statutory authorization. The Court rejected this argument, holding that: (1) the State Health Care Facilities Act assigned the State Department of Health, as the sole state agency charged with comprehensive health planning and the duty of striving to achieve the objectives of the federal Health Planning Act (including equal access by all people to quality health care services), overall responsibility for administering the state's health policy including authority to condition licensure on the providing of "fit and adequate" services; and (2) implicit in the foregoing responsibilities was the power to allocate beds to indigents.

(2) Pee Dee Regional Health Systems Agency, Inc. v. Department of Health and Environmental Control No. 79-CP-40-3626 (S.C.Ct.C.P. May 13, 1981)

An HSA and others brought an action against the Department of Health and others seeking judicial review of a decision approving an application for a CON to construct a "long-term care rehabilitation facility," described as a unique facility providing both traditional nursing home services and extensive, specialized rehabilitative services. In granting the CON for the facility the state agency indicated that it would assure that the proposed facility would in fact provide unique, needed specialized rehabilitative services and not merely traditional nursing home services (for which no need was shown) by conditioning the facility's license on the performance of such specialized services. The Court concluded that the Board possessed the authority to attach such a condition to a licensure approval, even in the absence of express statutory authorization.

(3) Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission No. 80-20049-AA (Mich.Cir.Ct. Oakland County March 27, 1981), aff'd, 312 N.W. 2d 422 (Mich.App. 1981), app. den. No. 68442 (Mich. Mar. 11, 1982)

A hospital corporation brought an action seeking judicial review of a state agency denial of its application for a CON to construct a new hospital. The state agency decision was based in part on an unpublished criterion which created a preference for existing facilities, including providing that "the highest priority will be granted to existing facilities seeking a CON to modernize or correct licensing deficiencies." The state agency justified this preference as being inherent in the CON statutory policy and a necessary means of encouraging hospitals to bring facilities into compliance with licensure standards. There was evidence that at the time plaintiff's application was being reviewed the state agency knew that the existing hospital in town would soon be applying for a CON to rebuild its facility to remedy licensing deficiencies. The Court held that the state agency preference for existing facilities was beyond statutory authorization because: (1) the state CON statute did not evince a legislative intent to prefer and perpetuate existing facilities; and (2) the CON statute was not a licensing measure, nor did it evince a legislative intent that it be used to encourage remedial action by facilities with licensing deficiencies.

c. State Health Planning and Federal Antitrust Laws

(1) *Cf. Huron Valley Hospital, Inc. v. City of Pontiac* 466 F.Supp. 1301 (D.Mich. 1979), *vacated* 666 F.2d 1029 (Sixth Cir. 1981) ("Huron v. Pontiac I")

A corporation formed to build a new hospital in Pontiac brought an action against the existing public hospital in Pontiac, the city, the HSA, and various state and federal officials alleging a conspiracy to exclude it from the market of providing hospital facilities and services in violation of federal antitrust laws, carried out in the context of opposition to the corporation's CON application. The corporation's application for a CON to construct the proposed hospital was opposed by the existing hospital, recommended for denial by the HSA, and denied by the state agency; several months later the existing hospital's application for a CON to renovate its facilities was approved. The corporation sought state court judicial review of the denial of its application (*see Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission*) and brought this action. The trial court had held that a combination of prior resort doctrines - exhaustion of state remedies, ripeness, and abstention - barred resolution of the antitrust claim. In the alternative, the trial court ruled on the merits that: (1) the regulatory actions of the state agency and the HSA alleged in the complaint to have been violative of the antitrust laws were exempt from the antitrust laws under the "state action" defense; (2) the alleged conspiracy was also exempt from antitrust liability under the *Noerr-Pennington* doctrine because the defendants sought only to secure favorable administrative action, in the form of denial of the corporation's CON application by duly authorized government agencies, and because the corporation did not allege that the defendants engaged in the kind of bad faith tactics which would indicate that their participation in the review process was a mere sham to disguise their anti-competitive intentions. The Court of Appeal upheld the trial court ruling on prior resort doctrines and vacated its rulings on the merits.

(2) *Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield of South Carolina, Inc. and Palmetto-Lowcountry Health Systems Agency* C/A No. 81-1639-1 (D.S.C. Nov. 2, 1982), 1983-2 Trade Cas. (CCH) ¶65,674

Several physician groups who performed CT scanning in non-institutional settings brought an action against BC/BS and a HSA alleging a conspiracy to exclude them from the market in violation of federal and state antitrust statutes. They asked for damages and injunctive relief. Since 1977, BC/BS had denied reimbursement for CT scanning not operated by a hospital nor approved by a health planning agency. In

1979 an HSA study of CT scanning recommended that scanners be located only in hospitals and that all third-party payors deny reimbursement for scans performed by CT scanners for which no CON had been obtained. The Court granted a summary judgement for the HSA, holding that the HSA was exempt from antitrust liability under the "state action" exemption because it followed a clearly articulated and affirmatively expressed state policy set forth in the state health planning statute, and the state actively supervised the HSA by requiring it to submit its HSP and AIP to be constantly reviewed by the state.

(3) Phoenix Baptist Hospital and Medical Center v. Samaritan Health Services No. 81-5848 (U.S.Ct.App. Ninth Cir. Aug. 25, 1982)

A hospital brought an action against, among others, a competitor (a joint venture which had been formed by two hospital corporations to obtain a CON and construct a hospital in the Phoenix area) alleging a conspiracy to monopolize, and exclude it from, the local institutional health services market. In 1979 the joint venture had been the winner and plaintiff one of the losers in a fifteen-applicant comparative review of projects to construct a new facility in the area. In 1980 the plaintiff had filed an application for a CON to add beds. The joint venture appeared in opposition at the administrative hearing on the application and, after an initial approval, brought an administrative appeal which resulted in final disapproval of the project. This action followed.

The Court held that the joint venture was not subject to antitrust liability for its actions in opposing the plaintiff's CON application because its actions fell squarely within the Noerr-Pennington exemption from antitrust liability. [Noerr-Pennington provides an antitrust exemption for actions which, though undertaken for an anti-competitive purpose, are protected by the First Amendment right to petition the government. It incorporates an exception to the exemption for so-called "sham" actions, i.e. abuses of process such as baseless, repetitive proceedings intended to deny a competitor meaningful access to a government body-Ed.] The Court rejected plaintiff's argument that the joint venture's conduct fell within the "mere sham" exemption to Noerr-Pennington, noting that its conclusion was reinforced to some extent by the fact that the joint venture's attempt to influence the CON decision-making process had been successful.

The Court also held that the action of the joint venture in applying for a CON for its new hospital was shielded from antitrust attack by the "state action" exemption from antitrust liability because the state CON statute compelled parties to obtain a CON to enter the hospital market and the state CON statute: (1) clearly expressed a plainly articulated state and federal policy of statutory division of markets; and (2) constituted a regulatory scheme actively supervised by the state, since the state continually evaluated the health care supply and demand in each appropriate geographic area and allocated construction permits for new facilities only when the need arose. The Court indicated in dicta that the action of the two hospital corporations in forming the joint venture to obtain a CON would not be exempt under the "state action" doctrine.

(4) Hospital Building Company v. Trustees of the Rex Hospital 691 F.2d 678 (4th Cir. 1982)

A newly-built hospital (HBC) brought an action against a competitor (Rex), and its administrator and trustees alleging that they conspired with the director of the local CHP agency, an Assistant Attorney General assigned to the state CON agency, and the state Blue Cross/Blue Shield plans to exclude HBC from the local market for inpatient services and to monopolize the market by, among other things, preventing HBC from acquiring a CON or delaying the granting of the CON.

In 1969 Rex and Wake Memorial were the leading hospitals in Raleigh, North Carolina; HBC operated a smaller facility. In 1969 Rex, Wake, the local CHP, and others organized a Joint Long Range Hospital Planning Committee to study the need for inpatient services in the area. It concluded that Rex and Wake should undergo major expansion and HBC lesser expansion. In 1971 the state adopted a CON statute and HBC applied for a CON to replace and expand its facility. The local CHP agency recommended denial and, following approval of the application by the state, brought an unsuccessful administrative appeal and action for judicial review. That action was rendered moot by the decision of the state Supreme Court in 1973 striking down as unconstitutional the state CON statute (In Re Certificate of Need for Aston Park Hospital). However, HBC's hospital was not built until 1977 because of rising interest rates, delay created by the need to obtain 1122 approval (the state entered into a 1122 agreement in 1973), and an allegedly discriminatory BC/BS reimbursement policy.

The case came before the Fourth Circuit after a $7.3M jury verdict for HBC. The Court reversed and remanded for a new trial. The Rex defendants had argued at trial, apparently unsuccessfully, that their conduct and that of their alleged co-conspirators in participating in and ultimately seeking judicial review of HBC's CON application was exempt from antitrust liability under the Noerr-Pennington defense. HBC alleged, apparently successfully, that Rex had taken control over the ostensibly neutral CHP agency, inducing it to file spurious litigation, and that Rex had attempted to suborn the neutrality of an assistant AG - allegations intended to place Rex within the sham exception to Noerr-Pennington. In the course of overturning the jury instructions on Noerr-Pennington (for failure to give sufficient weight to the "intent to misrepresent" and "denial of access" elements of the sham exception) the Court held that the conduct of the assistant AG, consisting of offering to meet with representatives of HBC and the local CHP to help them effectively participate in the state hearing on HBC's CON, and meeting with CHP representatives, was insufficient evidence on which to infer that the assistant AG was a participant in an antitrust conspiracy.

(5) North Carolina v. P.I.A. Asheville, Inc. 740 F.2d 274 (4th Cir. 1984)

A state Attorney-General brought an action against a psychiatric hospital corporation alleging that it created a monopoly in violation of federal and state antitrust laws when it acquired the second of the two psychiatric hospitals in a city. It had earlier acquired the first hospital. At the time of the acquisitions in 1980-81, the state CON law provided for coverage of all acquisitions of existing health facilities, and P.I.A. had obtained a CON for each acquisition. The second hospital acquisition did not involve a change in bed capacity or services. The District Court granted summary judgment for P.I.A., holding in the alternative that the acquisition was immune from antitrust scrutiny under the implied repeal doctrine and that the acquisition was exempt under the "state action" doctrine. The Court of Appeals initially affirmed the District Court on implied repeal, concluding that to allow the antitrust laws to strike down transactions approved by state health planning agencies would unduly interfere with the operation of NHPRDA and subject participants in the CON process to conflicting standards. [722 F.2d 59 (4th Cir. 1983)].

On rehearing the Court of Appeals reversed the District Court on both the state action and implied repeal grounds. Regarding state action, the Court held that the acquisition by P.I.A. of the second hospital was not immune from antitrust scrutiny under the state action doctrine because: (1) To qualify for state action immunity a private claimant must show that the allegedly immune transaction was undertaken pursuant to a clearly articulated state policy and the policy must be subject to ongoing state supervision. (2) The first element of this test was met in this case since the state's CON coverage of the acquisition represented a clearly articulated state policy. However, the second element was not met since an examination of the state CON program shows that after a proposed acquisition passes CON review the state makes no attempt to monitor the use of that acquisition. The Court stated: "There is no active supervision at all. No provision, for example, regulates post-acquisition prices. The state does provide for penalties for failure to obtain a certificate of need in situations where one is required, and for failure to incur a financial obligation authorized by a certificate of need. But the statute in no way attempts to monitor the conduct of health care providers to be sure it is in harmony with the expressed goals of the NHPRDA, and with the Findings of Fact in the North Carolina legislation. The mandatory certificate of need requirement constitutes the sum of North Carolina's foray into the health services regulation arena established by the NHPRDA. This point is well-illustrated here, where P.I.A. has admitted to raising its prices after it bought [the second hospital]." (740 F.2d at 278). The Court also observed that P.I.A.'s conduct was self-initiated and not in any way advocated or compelled by the state, and that some state action immunity cases have emphasized that compulsion by the state is a necessary prerequisite to a finding of implied exemption from the antitrust laws.

(6) Garst v. Stoco 604 F.Supp. 326 (E.D. Ark. 1985)

A disapproved CON applicant brought an action against a hospital and associated persons alleging, among other things, a conspiracy in violation of federal and state antitrust laws to monopolize and exclude it from the local birthing center market. Plaintiff's application for a four-bed, non-hospital birthing center had been disapproved by the SHPDA following a negative recommendation by the local non-profit HSA. The hospital (which planned a similar project) and other defendants actively opposed the application before the HSA including writing letters, meeting with HSA members, soliciting others to write letters, circulating petitions, and soliciting attendance at the HSA hearing on the application.

The defendants argued that they were protected from antitrust liability for such actions by the Noerr-Pennington doctrine. The Court agreed, holding that: (1) The HSA was a government body with respect to its recommendations concerning certificate of need and defendants' opposition to the application before the HSA was protected by Noerr-Pennington even if motivated solely by anti-competitive intent. The Court noted that the plaintiff had not alleged any fraudulent conduct by defendants or conspiracy with HSA members that might invoke the sham exception. (2) Hospital Building Co. v. Trustees of the Rex Hospital set forth a "narrow rule of reason" for antitrust analysis of health planning/CON related activities of providers under which such activities would be reasonable and non-violative if undertaken in good faith and with actual, intended effects within those envisioned by then-existing federal health planning legislation. Plaintiffs asserted that Rex's "narrow rule of reason" was intended to expand the sham exception by incorporating a "good faith" limitation on the application of Noerr-Pennington to conduct before HSAs, such that unless a party's opposition to a CON before an HSA was in good faith it would fall within the sham exception. The Court declined to accept this argument, observing that there was sufficient protection against abuse of the HSA process in the existing sham exception and in the CON review process itself under which the SHPDA was the ultimate decision-maker. (3) The Court noted that it did not rule on the extent to which HSAs themselves might be protected from antitrust immunity.

(7) General Hospitals of Humana, Inc. v. Baptist Medical System, Inc. No. LR-C-84-455 (U.S.D.C., E.D. Ark. March 21, 1985)

A disapproved applicant for a CON to construct a new hospital brought an action against competitor hospitals, Blue Cross, HSA and SHCC members, and others alleging a conspiracy to monopolize and exclude it from the local hospital market by, among other things, opposing the application before the HSA and SHCC. Blue Cross filed an affidavit and statement of material facts not in issue, apparently uncontested by the plaintiff, attesting that it had not consulted with others on its decision to oppose the application, its only opposition to the application was before government bodies, and the opposition was motivated by good faith belief the project was unnecessary. The Court granted Blue Cross' summary judgment motion, ruling that no facts existed to support the complaint and, citing Garst v. Stoco, that Blue Cross' opposition could not be the basis of antitrust liability.

(8) DeSoto Medical Center, Inc. v. Methodist Hospitals of Memphis 604 F.Supp. 307 (S.D. Miss. 1985)

A disapproved CON applicant brought an action against competitor hospitals, the HSA, the state CON agency, and others alleging a conspiracy in violation of federal antitrust laws to exclude it from the local hospital market by preventing it from obtaining a CON. The complaint alleged that both HSA and state agency officials or employees acted in bad faith contravention of their own regulations and guidelines in the course of denying the CON. The Court denied a motion to dismiss or for summary judgment filed by the state agency, holding that: (1) the Eleventh Amendment [which prohibits certain suits in federal court against a state by its citizens and citizens of other and foreign states] does not bar an antitrust suit in federal court against a state; and (2) although the "state action" antitrust exemption immunizes sovereign actions by the state, the hospital's allegations of actions by the state agency in excess of its legislative grant of authority raised factual questions precluding granting a motion to dismiss or for summary judgment based on a "state action" defense.

d. State Health Planning and Medicare Reimbursement

(1) Metropolitan Medical Center and Extended Care Facility v. Harris 693 F.2d 775 (8th Cir. 1982), infra p. 148.

(2) Faulkner Hospital Corporation v. Schweiker No. 82-1528 (1st Cir. Mar. 10, 1983), aff'g, 537 F.Supp. 1058 (D.Mass. 1982), infra p. 148.

e. State Health Planning and Local Ordinances

(1) Cf. Framingham Clinic v. Board of Selectmen of Southborough 367 N.E.2d 606 (Mass.Sup.Jud.Ct. 1977)

A group proposing to establish a gynecological clinic brought an action seeking to enjoin the enforcement against it of a town zoning ordinance forbidding "abortion clinics." The state CON regulations required a showing that the proposed project would not be in violation of any local zoning ordinance; the project was proceeding through CON review when the ordinance was adopted. The Court held that the zoning ordinance was invalid because it unduly burdenend women's constitutionally protected privacy rights in respect to termination of pregnancy. A concurring opinion took the position that the ordinance was invalid because, by adopting the state certificate of need statute, the legislature had delegated the authority to regulate health facilities including the location of such facilities to the state health department, preempting the inconsistent local ordinance. The opinion stated that the inconsistency arose because the ordinance excluded abortion clinics altogether, and that there would be no conflict if the ordinance imposed reasonable regulation as to location within the town.

(2) Urban Farms, Inc. v. Borough of Franklin Lakes 431 A.2d 163 (N.J.Super. App. Div. 1981)

The proponent of a nursing home brought an action seeking judicial review of a 1977 denial by a municipality of its conditional use permit application and judicial review of the validity of a 1979 municipal ordinance striking nursing homes from the list of permissible conditional uses. In 1977 the ordinance provided for "hospitals and nursing homes" as a category of permissible conditional uses in residential areas, upon a showing, among other things, that the proposed use was "reasonably necessary for the convenience of the community." The municipality denied the application in part on the grounds that reasonable necessity for the convenience of the community meant only the convenience of the municipality itself, and by virtue of its small and presently youthful population the borough did not need a nursing home. After a lower court overturned the denial, the municipality amended the ordinance as indicated above. The Court held that the nursing home was entitled to a conditional use permit under the 1977 ordinance because, among other reasons, the state comprehensive health planning legislation required a state agency determination that the general community to be served by the proposed facility (not just the municipality in which it is to be located) needed the services of that facility and the ordinance standard of reasonable necessity for the convenience of the community, if not superseded by the judgement of the state agency, must nevertheless in its application and substantive content accord with and incorporate that judgement.

f. State Health Planning and Federal Bankruptcy Act

(1) Schatzman v. Dept. of Health and Rehabilitative Services ("In re King Memorial Hospital I") 4 B.R.704, 6 B.C.D. 634, 2 CBC.2d. 639, CCH BANKR.L.RPTR ¶67,685 (U.S. Bankruptcy Ct. S.D. Fla. 1980)

A trustee in bankruptcy brought an action to enjoin the state agency from taking action to forfeit the debtor hospital's CON exemption.

The state CON statute provided that projects for which land was acquired and preliminary plans filed prior to July 1, 1973 were exempt from CON. In 1978 the state legislature repealed this grandfather exemption, effective July 1, 1979. DHRS notified King that it held an exemption to construct a 126-bed hospital and that to preserve the exemption the project would have to be under physical and continuous construction pursuant to final construction plans approved by DHRS by July 1, 1979. In June, 1979 DHRS approved plans prepared by an architect and engineer hired by King for commencement of foundation work on the construction project. Between June 25 and June 30, 1979 a building permit to erect the foundation was received, a binding construction contract was entered into, equipment was rented and the construction site was cleared by bulldozer, a survey was taken, and a groundbreaking ceremony was held. Site clearing and bulldozing continued during July and on July 31, 1979 DHRS approved schematic drawings for the project. On August 6, 1979 DHRS notified King of the need to maintain continuous construction activity to continue to preserve its exemption; King responded on August 15, 1979 by sending DHRS a copy of the construction contract and advising that financing arrangements were being finalized. On October 2, 1979 King filed a petition for bankruptcy under Chapter XI and on November 30, 1979 DHRS notified King that its CON exemption was forfeited and that it was entitled to an administrative hearing on the matter.

Section 362 of the Bankruptcy Code operates as an automatic stay of, among other things, the commencement or continuation of a judicial, administrative, or other proceeding against the debtor that was or could have been commenced before the commencement of the bankruptcy case or to recover a claim that arose before the commencement of the bankruptcy case. (11 U.S.C. §362(a)(1)(1978)). Section 362(b)(4) provides an exception to the automatic stay for, among other things, the commencement or continuation of an action or proceeding by a governmental unit to enforce such governmental unit's police or regulatory power.

The Court held that DHRS' forfeiture determination was subject to the automatic stay and was not within the "police power exception" to the automatic stay because: (1) the fact that DHRS did not initiate its enforcement action until late November 1979 when it could have initiated action as early as July 2, 1979, and that once having filed a voluntary petition it would seem unimaginable that the debtor would have funds to construct a 126-bed facility, indicated that urgent protection of the public health and welfare was not the reason for commencement of the DHRS action; and (2) the state CON statute does not appear to have been enacted to protect health and welfare but instead to stimulate the establishment and achievement of community-oriented health goals by providers, consumers, and public agencies. The Court based its decision in large part of its reading of Sisk v. Commonwealth of Massachusetts ("In re Saugus General Hospital, Inc.") 4 B.C.D. 1160, 19 C.B.C. 651, 1 C.B.C.2d 26, CCH BANKR. L. RPTR. ¶67, 108 (D.Mass. 1979). In that case the receiver of a hospital debtor under former Ch. XI filed an action seeking a judgement that the state public health agency's termination of the hospital's operating license was in violation of the automatic stay provision of Bankruptcy Rule 11-44(a). The agency terminated the hospital's license pursuant to a regulation providing that a hospital which discontinued operations following its bankruptcy petition, as Saugus had done, was deemed to have abandoned its license. Ruling for the receiver, the Court noted the police power exemption to the automatic stay rule but found it inapplicable because the health agency's automatic licensure revocation did not involve a public welfare exercise of the police power but instead was based on the hospital's financial insolvency. [Compare In re National Hospital and Institutional Builders Company 80 CIV. 6073 (U.S.D.C., S.D.N.Y. Feb. 25, 1981) (automatic stay under former Ch. XII does not apply to city's proceedings to revoke nursing home debtor's certificate of occupancy under local zoning laws); In re Parkchester General Hospital 4 B.C.D. 292, 17 C.B.C. 251, CCH BANKR. L. RPTR. 66,822 (U.S. Bankruptcy Ct. S.D.N.Y. 1978) (Automatic stay under former Ch. XI was applicable to proceeding to revoke debtor hospital's license but the Court lifted the stay because the public policy of availability of high quality health services and protection of health required that the Health Department be permitted to recommence its investigation of the operations of debtor and its supervising physicians)-Ed.]

(2) Schatzman v. Department of Health and Rehabilitative Services ("In re King Memorial Hospital, Inc. II") 19 B.R. 885 (U.S. Bankruptcy Ct. S.D. Fla. 1982)

A trustee in bankruptcy brought an action seeking an order declaring it the possessor of a CON exemption for a project to construct a 126-bed facility. The factual background of this case is described in the annotation to Schatzman v. Dept. of Health and Rehabilitative Services ("In re King Memorial Hospital, Inc. I"), *supra*.

The Court held that it had jurisdiction over the subject matter of the proceeding and that, the debtor having filed a petition under Ch. XI, the case was subject to the U.S. Bankruptcy Code. The Court's rulings on the trustee's entitlement to the CON exemption are annotated elsewhere in the GUIDE.

(3) Schatzman v. Nova Hospital Group, Inc. ("In re King Memorial Hospital, Inc., III") 28 B.R. 115 (U.S. Bankruptcy Ct.S.D. Fla. 1983)

A trustee in bankruptcy brought an action to foreclose on its mortgage and security agreement against an investor (Nova) for non-payment under a promissory note, to recover possession of the hospital construction site it had sold to Nova, and for a declaratory judgement as to its continued ownership of a CON exemption to construct a 126-bed hospital facility on the site. The factual background to this case is set forth more fully in "King I" and "King II", *supra*. After the "King II" decision the 126-bed hospital project and site had been sold to Nova. The Court held that following its reacquisition of the property the plaintiff retained the right to proceed to construct or otherwise dispose of the right to build the 126-bed facility subject to the jurisdiction of the Bankruptcy Court.

g. State Health Planning and Professional Licensure Laws

(1) Women's Medical Center at Howell v. Finley 469 A.2d 65 (N.J. Super. App. Div. 1983), *infra* p. 67.

STATUTORY CONSTRUCTION OF FEDERAL AND STATE HEALTH PLANNING LAWS

1. Construction of state CON law in light of NHPRDA

a. Pratt v. Board of County Commissioners 597 P.2d 664 (Kan. 1979)

A group of taxpayers brought an action against their local government to enjoin the issuance of general obligation bonds for the construction of a new hospital. In 1976 the new hospital project had been approved and granted a CON by the 314(b) agency (the regional planning agency established by state law to implement the Comprehensive Health Planning and Public Health Services Amendments of 1966 NHPRDA, and the county had initiated the process of issuance of general obligation bonds to finance the project. However, the issuance was halted (for reasons not relevant here) by the courts. Subsequently, the state adopted new legislation to bring itself into compliance with NHPRDA, replacing the regional planning agency with a state agency as the final arbiter of CON applications, but containing a grandfather clause exempting projects with valid CONs under the prior CON law. Thereafter, to avoid the problem which had led to the halting of the earlier bond issue, a statute authorizing a bond issuance for the project was adopted. It required that the project possess a CON issued under the provisions of the new state CON law but was ambiguous and unclear as to whether this meant that a new CON was required or whether a CON under the old law, grandfathered into the new law, would suffice. In an alternate holding the Court interpreted the bond authorizing statute to require a new CON, basing its holding in part on its understanding that such a requirement would be in compliance with NHPRDA. Since the project did not have a new CON, the Court enjoined the issuance of bonds to finance the project.

b. State ex rel. Metzler v. Sisters of Charity of Leavenworth 605 P.2d 100 (Kan. 1980)

The State of Kansas brought an action to enjoin a hospital from implementing a cardiac surgery unit without obtaining a CON. The state statute covered substantial changes in services, such as the addition of a cardiac surgery unit, only if their cost exceeded the capital expenditure threshold. The cost of the proposed cardiac unit did not. The federal statute and regulations required complying state CON programs to cover substantial changes in services regardless of cost. The state argued that the Court should interpret the state law to cover the project since the intent of the state legislature was to adopt a statute conforming to federal requirements. The Court declined to look to NHPRDA and regulations to interpret the state CON statute because the state law was clear and unambiguous.

c. Hale v. Petit No. CV81-2 (Me.Super.Ct. Kennebec County (Feb. 28, 1981), aff'd on other grounds, 438 A.2d 226 (Me. 1981).

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the granting of the other. In reviewing the plaintiff's allegations of procedural defects in the administrative adjudication of the applications, the Court looked to NHPRDA to aid in interpreting the state CON statute on the issue of whether the state's CON administrative proceedings were subject to the state Administrative Procedures Act. In addition, in reviewing the issue of plaintiff's standing to bring the action the Court used the definition of the term "persons directly affected" contained in the federal health planning regulations (42 CFR §123.407(a)(7)(i) (1979)) to define the same term and the term "person aggrieved" as they appeared in the state statute.

d. South Central Health Planning and Development Inc. v. Commissioner 628 P.2d 551 (Alaska 1981)

An HSA brought an action to enjoin construction of a skilled nursing unit within a home for the aged on the grounds that the facility had failed to submit the project to CON review. In determining whether the project was covered under the state CON statute, the Court reasoned that the definition of "skilled nursing facility" in federal regulations should be used to interpret that term as employed (but not further defined) in state CON statute because the state law was adopted to conform to the federal law, and was meant to be no less comprehensive in its definitions of covered facilities.

e. Rehab Hospital Services Corp. v. Health Systems Agency of Southwestern Pennsylvania 475 A.2d 883 (Pa. Cmwlth. 1984)

A hospital and a state Health Department brought an action seeking judicial review of a state CON appeals board's decision overturning the Secretary of Health's approval of the hospital's CON application to construct a rehabilitation hospital. The Secretary's approval, which was inconsistent with the recommendation of the HSA and the SHPDA staff, was based in part on project per diem costs lower than existing facilities and was intended to foster competition in an area where rehabilitation services were often provided in acute care hospitals at a much greater cost. The state CON statute contained an express legislative purpose to, among other things, encourage innovation and improved delivery methods. The Court observed that under the state CON statute the state Health Department must act as a SHPDA, following the directives and purposes of NHPRDA and the state statute to foster competition and reduce costs, particularly by the encouragement of health care facilities which can treat inpatients at a lower per diem rate.

f. Chambery v. Axelrod 474 N.Y.S.2d 865 (App. Div. 1984)

A nursing home brought an action seeking judicial review of a SHPDA denial of its application for a bed addition CON. The nursing home historically had a low number of Medicaid admissions. Although it had 42-50% Medicaid patients at the time of application and CON hearing, it had an admissions policy reserving the right to discharge previously private paying patients who became Medicaid-dependent. The application was comparatively reviewed in a "batch" and the application of another nursing home without admission reservations was approved in preference to that of the petitioner.

The Court upheld the SHPDA decision on the grounds that: (1) State regulations set forth as CON review factors, "the current and projected population characteristics of the service area, including relevant health status indicators and socio-economic conditions of the population" and federal regulations (42 CFR §123.412(a)(6)(iii)) provided that a SHPDA reviewing expansion proposals must consider the extent to which the applicant serves Medicaid patients; (2) the vast majority of persons in the applicant's county needing long-term care were Medicaid-dependent; and (3) recognition of the characteristics and socio-economic conditions in the user population to be served, which demonstrated the need for Medicaid-sponsored beds, made the state's decision both logical and reasonable.

g. St. Joseph's Hill Infirmary, Inc. v. Mandl 682 S.W.2d 821 (Mo. App. 1984)

A nursing home brought an action seeking judicial review of a SHPDA decision granting a CON to its competitor to construct a nursing home. The state CON statute required the SHPDA to conduct a hearing on an application at the request of any "affected person" (defined as the applicant, the HSA, health care facilities in the area, and the public) and gave the applicant and the HSA the right to seek judicial review. The nursing home argued that it was the intent of the state legislature in adopting the CON statute to provide whatever was required by NHPRDA, and argued further that NHPRDA regulations granted competitors standing to appeal CON decisions. In the course of holding that the nursing home lacked standing to seek judicial review, the Court observed that the state CON law was enacted in response to NHPRDA but refused to conclude that the state law automatically encompassed whatever might be included in NHPRDA regulations because: (a) the state law does not clearly support such a interpretation; and (b) the federal regulations are not mandatory upon the states as they are subject to waiver by the Secretary or subsequent amendment.

h. In re HCA Health Services of Wyoming, Inc. 689 P.2d 108 (Wyo. 1984)

A competitor brought an action seeking judicial review of a SHPDA decision granting a CON to its competitor for facility replacement and addition of beds. The SHPDA had approved the application following informal public meetings. The state CON statute required the SHPDA to notify affected persons of the commencement of a CON review and to conduct a "public meeting" on each CON application. State CON regulations provided for an informal public meeting without opportunity for sworn testimony, confrontation, or representation by counsel. The state APA provided for formal, "trial-type" hearing procedures in all "contested cases", defined as cases where the law, independent of the APA, required a formal hearing.

The Court held that the SHPDA was required to conduct a formal APA hearing on the CON application at the request of the plaintiff because: (1) States choosing to participate in NHPRDA must abide by the procedural due-process requirements of the Act. The Court cited Park East Corp. v. Califano and Greater St. Louis HSA v. Teasdale for this proposition. (2) NHPRDA and implementing regulations require a SHPDA to conduct a formal hearing at the request of affected persons (42 U.S.C. §300n-1(b)(1), (12)(A); 42 C.F.R. §123.401, 410(a)(8). (3) The "public meeting" requirement of the state CON statute should be read to derive meaning and substance from the NHPRDA formal hearing requirements. The Court indicated that this reading of the "public meeting" requirement would effectuate the purpose of the legislature to adopt a certificate of need review process that complied with federal requirements and qualified the state for financial assistance, and that the overall statutory scheme of CON review including the availability of judicial review supported a reading in which the term "public meeting" incorporated a formal, trial-type hearing. (4) Under the foregoing reading, the term "public meeting" in the CON statute triggered the contested case provisions of the state APA and any affected person as defined by pertinent federal and state CON regulations, including the plaintiff, would be entitled upon request to participate as a party in such contested-case CON proceedings.

i. Farmworker Rights Organization, Inc. v. Dept of Health and Rehabilitative Services 430 So.2d 1 (Fla. Dist. Ct. App. 1983)

A farmworkers' association brought an action under the state APA seeking a determination as to the validity of the state CON regulatory review criterion on access. The CON criterion did not specifically address the issue of the degree to which medically underserved persons, including low income and minorities, should have access to a proposed project, but it did have a general standard requiring consideration of community need. The state CON statute

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authorized the SHPDA to issue and deny CONs "in accordance with present and future federal and state statutes." (Fla. Stat. §381.494(7)(a) (1981)). NHPRDA requires complying SHPDAs to include among their review criteria consideration of the extent to which the proposed services will be accessible to all residents of the area to be served (42 U.S.C.§300n-1(c)(6)(E)) and implementing federal regulations require SHPDAs to adopt criteria based on specified access standards set forth therein. (42 C.F.R. §123.412(a)(5), (6) and 123.413). The Court struck down the state regulatory review criterion, holding that: (1) in order to be valid under the state CON statute the SHPDA's regulations must be in accordance with NHPRDA and consistent with federal regulations on the same subject; and (2) the state CON regulatory review criterion was inconsistent with federal regulations and consequently not in accordance with NHPRDA since: (i) its criterion for consideration of community need was not broad enough to include consideration of the access criteria mandated by federal regulation; (ii) the SHPDA had no policy of complying with the federal "access" criteria when reviewing every CON application; and (iii) in practice the SHPDA sometimes failed to specifically address the needs of low income and minority persons in CON proceedings.

j. Humana Medical Corp. v. State Health Planning and Development Agency 460 So.2d 1295 (Ala.Civ.App. 1984)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to add beds. The application was denied for failure to satisfy the review criteria of "community need" and "cost containment/less costly alternative" on the grounds that there was an area bed supply excess and that better utilization of existing area hospital beds would foster cost containment. The Court held that the standard of judicial review of state CON decisions was the "arbitrary, capricious, or not made in compliance with applicable law" provision of the NHPRDA regulations (42 C.F.R. §123.410 (14)(i)) which was incorporated by reference into the state CON statute.

k. Manor Healthcare Corp. v. Northwest Community Hospital 472 N.E.2d 492 (Ill. App. 1984)

A competitor brought an action seeking judicial review of a state agency decision granting a CON to its competitor to construct a 200-bed nursing home. The Court held, among other things, that the competitor had standing to seek judicial review of the state agency decision because: (1) the state CON statute had been amended in 1982 to grant standing to persons "adversely affected" as part of a general legislative effort to bring the law into compliance with NHPRDA and its regulations; and (2) although state law did not define "adversely affected", NHPRDA regulations defined "persons adversely affected" to include health care facilities such as the plaintiff competitor located in the area and providing similar services to those under review. (42 C.F.R. §123.410(a)(14) incorporating by reference 42 C.F.R. §123.401 (1984)).

1. Bradbury Memorial Nursing Home v. Tall Pines Manor Associates 485 A.2d 634 (Me. 1984)

A nursing home (Bradbury) brought an action seeking judicial review of the issuance of a CON to its competitor (TP) for new nursing home construction. The state CON statute and regulations provided that the time period for review could extend 150 days. The state agency's Procedures Manual contained a provision not formally adopted as a regulation stating that the agency's failure to notify a CON applicant of its decision within the agency's deadline would have the effect of a decision to deny the CON. The state agency awarded TP a CON after the expiration of the 150-day time period. Bradbury argued, among other things, that the TP application had been automatically denied upon expiration of the 150-day period by operation of the Procedures Manual provision. The Court rejected this argument for several reasons, among them that if the Procedures Manual were interpreted to provide for automatic denial or "pocket veto" it would contravene federal CON regulations which provide that a CON may not be denied solely because the state agency fails to reach a decision. 42 C.F.R. §123.410(a)(17) (1983). The Manual provision should not be interpreted to do so, because the state CON statute declared the federal regulations binding upon the state by providing that an express purpose of the statute was to provide for a CON program meeting the requirements of NHPRDA and its accompanying regulations.

2. Interpretation and Legislative Intent of State CON Statute

a. Cooper River Convalescent Center, Inc. v. Dougherty 336 A.2d 35 (N.J.Super.App.Div. 1975)

A nursing home brought an action appealing the denial of its application for a CON to add SNF and/or ICF beds to its facility. The application was denied on the basis of a moratorium on the issuance of CONs which had been adopted by the state agency. The Court held that the state agency had the authority to adopt the moratorium because: (1) the state CON statute, which authorized the state agency to take actions to implement the public policy that "hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health" should be liberally construed to enable the agency to achieve the task assigned to it, and the courts should imply, where necessary, incidental powers necessary to achieve the legislative scheme; and (2) the moratorium furthered the legislative objective of properly utilizing health care services.

b. Moles v. White 336 So.2d 427 (Fla. Dist. Ct. App. 1976)

A physician brought an action seeking judicial review of a nonprofit community hospital's refusal to grant him staff membership. The physician alleged that the hospital was imbued with "state action" for purposes of application of constitutional requirements of due process, in part on the basis of pervasive governmental regulation including the state CON statute. The Court declined to find "state action"; ruling that by the passage of the CON statute the state had become involved in the planning of new hospital facilities, but the legislation did not suggest a legislative determination to become involved in the day-to-day management of these facilities.

c. Bakersfield Community Hospital v. Dept. of Health 77 Cal.App. 3d 193, 142 Cal.Rptr. 773 (1977)

A hospital proposing to construct a new facility on a site three miles from its existing facility petitioned for a writ of mandate commanding the SHPDA to determine that the proposed site was "adjacent" to the existing facility. Under state law projects to relocate hospital facilities in sites adjacent to their present location were exempt from CON. The Court concluded that the proposed site was not "adjacent", reasoning that the state legislature intended that words in statutory CON exemptions be narrowly construed to the end that exemptions not be unduly expanded and the legislative intent to control health care costs by health planning procedures not be circumvented.

d. Hamptons Hospital and Medical Center v. Moore 417 N.E.2d 533 (NY 1981)

A hospital brought an action to enjoin the state agency from reconsidering its prior determination regarding the hospital's application for a CON to construct a new hospital. The hospital claimed, among other things, that the state agency should be equitably estopped or prevented from re-evaluating the question of public need, on the grounds that the hospital had, in detrimental reliance on the initial determination, expended substantial time and money on the application. The Court refused to apply the doctrine of equitable estoppel to the state agency, concluding that it would be particularly inappropriate to do so because: (1) the agency had the duty of determining public need at the precise time and place and under the circumstances proposed, and (2) the legislatively-declared crisis in the cost to state and local governments of medical services and the long-lasting economic harm caused by excess hospital construction necessitated unshackled freedom of governmental oversight.

e. Women's Medical Center at Howell v. Finley 469 A.2d 65 (N.J. Super. App. Div. 1983)

Several medical office management corporations brought actions seeking a declaratory judgment that the first-trimester abortion/gyn. group practices operating within their offices (which were offered to the public under the name "Women's Centers" or similar names using the word "Center") were exempt from coverage as "health care facilities" under the state CON/licensure statute. In the course of ruling that the group practices were exempt, the Court observed that the state CON/facility licensure statute was intended primarily if not exclusively to contain the escalating costs of institutional delivery of health care and the private-practice exemption was based on the legislative perception that institutional cost factors were not relevant to the private practice of medicine.

f. Bradbury Memorial Nursing Home v. Tall Pines Manor Associates 485 A.2d 634 (Me. 1984)

A nursing home (Bradbury) brought an action seeking judicial review of the issuance of a CON to its competitor (TP) for new nursing home construction. The state CON statute and regulations provided that the time period for review under a comparative review cycle could extend 150 days. The state agency's Procedures Manual contained a provision not formally adopted as a regulation stating that the agency's failure to notify a CON applicant of its decision within the agency's deadline would have the effect of a decision to deny the CON. The state agency awarded TP a CON after the expiration of the 150-day time period. Bradbury argued, among other things, that the TP application had been automatically denied upon expiration of the 150-day period by operation of the Procedures Manual provision. The Court first held that Bradbury had standing to maintain the action because, among other reasons, the express legislative intent of the state CON statute to regulate distribution of health care facilities to avoid unnecessary duplication reflected a legislative purpose to regulate competitive interests and an injured competitor should therefore have standing to require compliance with the law. The Court then held that the TP application was not automatically denied because, among other reasons, interpreting the Procedures Manual provision not to require automatic denial was consistent with the overall purpose of the state CON statute to identify and satisfy as promptly as possible the need for additional health care services.

D. COMPOSITION AND SELECTION OF HSA GOVERNING BODIES

1. "Broadly representative" requirement

a. Minority Representation

(1) Aldamuy v. Pirro, 436 F.Supp. 1005 (N.D. N.Y. 1977).

Several minority community consumer representatives brought an action against an HSA and the Secretary of HHS challenging the composition and selection of the HSA governing body and the Secretary's approval of the governing body. The Court concluded that: (1) the decision of the Secretary of HHS approving the governing body was not arbitrary, capricious, an abuse of discretion, nor inconsistent with NHPRDA; (2) NHPRDA does not require that a governing body specifically include representatives of the inner-city geographic or socio-economic area; (3) NHPRDA does not prohibit seating government officials as consumers; and (4) whether or not particular minority group members selected to serve on the governing body really represent the minority community is the Secretary's decision, not to be overturned absent a showing that it is so arbitrary as to be clearly wrong.

(2) Hicks v. Southern Maryland Health Systems Agency No. R-80-2980 (U.S.D.C., D.Md. March 8, 1983)

Ex-employees of an HSA brought an action against the HSA and its Executive Director and the federal, state, and local governments alleging wrongful or discriminatory discharge in violation of rights protected under the First, Fifth, and Fourteenth Amendments; Title VI and VII of the Civil Rights Act; NHPRDA; and various other federal and state laws. The HSA was a "public regional planning body-type" HSA (See 42 C.F.R. §122.102(b)) established by four counties pursuant to a state statutory authorization. It had a governing board comprised of local government officials and a separate governing body, selected in accordance with NHPRDA and federal regulations, with exclusive responsibility for the agency's health planning functions (See 42 C.F.R. §122.109(d)). The plaintiffs were dismissed, in part, for breach of an internal policy and for allegedly making false statements adversely affecting the agency's reputation.

The Court dismissed the plaintiff's action holding, among other things, that the plaintiffs lacked standing to raise the claim that their termination violated NHPRDA on the grounds that the composition of the governing body was provider-dominated (and opposed to their consumer orientation) or that it was insufficiently representative of the minority groups of which they were members. Assuming arguendo that a cause of action on behalf of plaintiffs could be implied under NHPRDA, plaintiffs lacked standing because although they sufficiently alleged injury in fact, they failed to show (assuming a causal relationship) between the governing body composition and their discharge) that the governing body composition requirements were enacted to prevent discrimination in employment. The Court concluded that the statutory composition requirement was enacted to forestall a bias in favor of health care providers resulting, for example, in the compiling of a health systems plan not adequately serving the needs of area consumers.

b. Low Income Representation

(1) Texas ACORN v. Texas Area 5 Health Systems Agency Inc. 559 F.2d 1019 (5th Cir. 1977), reh. den., 565 F.2d 908 (5th Cir. 1978).

Health services consumers brought an action against an HSA and the Secretary of HHS challenging the composition of the HSA governing body. The Court held that: (1) the HSA governing body composition provisions of NHPRDA and regulations (particularly the term "broadly representative" [Sec. 1512(b)(3)(c)(i); 42 U.S.C.A. §3001-1(B)(3)(c)(i)]) do not require the application of a rigid formula to assure that the proportions of the governing body membership in each income category conform directly to proportions in each category in the population at large, and (2) neither the NHPRDA nor its regulations require that a governing body member have an income equal to that of the constituency he or she represents.

(2) Rakestraw v. Harris, No. C-77-635-A (N.D. Ga. Order June 30, 1980; Mem.op & order sub. nom. Rakestraw v. Schweiker Mar. 31, 1981; order Dec. 29, 1981; order Mar. 9, 1982)

Consumers of health services brought an action against the Secretary of HHS challenging the composition of an HSA governing body. The Court held that: (1) NHPRDA is unclear as to whether publicly elected officials on the HSA governing body should be included in the "count" in determining whether the governing body is broadly representative, and (2) if HHS chooses to count them it must do so in a uniform manner. The Court rejected the HHS methodology in which HHS counted publicly elected officials on the governing body earning less than $10,000 in the low income category but excluded publicly elected officials earning more than $10,000 from the middle and upper income categories.

2. "Broad participation" requirement

a. Greater St. Louis Health Systems Agency v. Teasdale 506 F. Supp. 23 (E.D.Mo. 1980)

An HSA and individual HSA members brought an action challenging, among other things, the validity of provisions of the Missouri CON statute requiring selection of HSA governing body members by local government officials. The Court held that the state CON statute's governing body selection process must be struck down, because it conflicted impermissibly with NHPRDA in that it did not provide the opportunity for broad participation in the selection process by area residents which is required by NHPRDA. Although it did not preclude some degree of participation, it failed to assure that area residents' views would be given any consideration.

3. Removal of Governing Body Members

a. Robinson v. Houston-Galveston Area Council 566 F. Supp. 370 (S.D. Tex. 1983)

Ex-members of the "governing body for health planning" (GBHP) of a public regional planning body HSA (H-GAC) brought an action seeking reinstatement on the GBHP and nominal damages. H-GAC was a Regional Planning Commission composed of elected officials created and organized under state law. At the times relevant to this case it was an HSA of the public regional planning body type. There had been a long-standing dispute over GBHP budget and personnel management between plaintiff GBHP members and H-GAC since 1976. In August, 1981, DHHS held a hearing on whether H-GAC should be terminated as an HSA or returned to conditional designation as a consequence of its inability to resolve this dispute. Plaintiffs testified against continued designation at the hearing and submitted their own designation application. H-GAC was returned to conditional designation following the hearing and ordered by DHHS to resolve the GBHP problems. In September, 1983 H-GAC summarily dissolved GBHP and established a new governing body for health planning. None of the plaintiffs were reappointed. GBHP members who testified on behalf of H-GAC at the DHHS hearing were reappointed. H-GAC bylaws provided for removal of GBHP members for good cause only. The plaintiffs alleged that their dismissal deprived them of constitutionally protected fourteenth amendment procedural due process and first amendment rights.

The Court denied plaintiffs the remedy of reinstatement, ordered H-GAC to hold a hearing at which plaintiffs could be informed of the grounds for their non-retention and challenge their sufficiency, and awarded nominal damages. It ruled that: (1) H-GAC is a political subdivision of the state and as such is bound by the fourteenth amendment. (2) Plaintiffs had a constitutionally-protected property interest in GBHP membership because: (a) pursuant to NHPRDA, DHHS regulations require HSA full-designation applicants to adopt bylaws providing for removal of governing body for health planning members "for good cause only" (42 C.F.R. §122.104(b)(1)(iii)(A)) and H-GAC had adopted such a bylaw; and (b) when H-GAC dissolved GBHP it was bound by the "for good cause only" obligation of the federal regulations, which created a legitimate claim of entitlement to GBHP membership; and (3) H-GAC denied plaintiffs' procedural due process rights by failing to provide them with pre-termination notice of reasons for termination and an opportunity to respond in writing and orally before the appropriate H-GAC officials and, following termination, with a full hearing.

The Court also held that H-GAC did not deny plaintiffs' first amendment rights by dissolving GBHP in retaliation for their criticisms. Plaintiffs had a constitutionally protected right to speak out against H-GAC but their protected speech was not the reason that H-GAC dissolved GBHP. H-GAC would have dissolved GBHP even in the absence of the protected conduct because it was threatened with termination of designation if it could not resolve the differences with GBHP and it was clear that the two groups could not function together.

E. HEALTH SERVICE AREA DESIGNATION AND REDESIGNATION

1. Health Systems Agency Steering Committee for Southeastern Pennsylvania v. Mathews, 566 F.2d 870 (3rd Cir. 1977).

A regional Comprehensive Health Planning agency and the HSA steering committee brought an action to enjoin the Secretary of HHS' revision of health service area boundaries. The plaintiffs alleged that Section 1511(b)(4) (42 U.S.C.A. §3001(b)(4)) required consultation with them by the Governor of the state (who had made the initial request for boundary revision) before the Secretary could make the revision. The Court agreed and enjoined the Secretary's redesignation until the proper consultation procedures were followed.

2. Health Systems Agency of Northeast Florida v. Califano No. 78-175-Civ-J-C (U.S.D.C. M.D. Fla. May 4, 1978)

An HSA brought an action seeking an injunction against the modification of its health service area boundary. The HSA asserted that Section 1511(b)(4) of NHPRDA (42 U.S.C.A. §3001(b)(4)), which states that the Secretary may review HSA boundaries if he "determines that a boundary no longer meets the requirements of [Section 1511(a)]", required the Secretary to formally find that existing boundaries do not meet the requirements of the Act. The Court denied the HSA's request for preliminary injunction finding that the statute and implementing regulations did not require formal findings for an area redesignation and that the Secretary was vested with a great deal of discretion in area designation and redesignation.

F. DESIGNATION OF PLANNING AGENCIES

1. HSAs

a. Mid-America Regional Council v. Mathews, 416 F.Supp. 896 (W.D. Mo. 1976).

An unsuccessful applicant to be designated as the HSA in Kansas City brought an action to set aside the conditional designation of the successful applicant. The Court held that: (1) the requirement of NHPRDA that the Secretary of HEW consult with the state governor concerning designation of an HSA and the requirement that the Secretary enter into a designation agreement with the HSA do not require the Secretary to perform those actions in person--subdelegatees may act for the Secretary; (2) the consultation requirement is satisfied if an opportunity is given the governor to submit written recommendations, criticisms, and views; (3) the requirements of NHPRDA that HSAs not be subsidiaries of or controlled by any other corporation or entity were not violated by designation of an HSA whose board of directors and personnel overlapped with the board and staff of the CHP 314(b) agency, nor were they violated by the fact that the HSA received financial assistance from the 314(b) agency, because such matters were insufficient to establish supervening control. Control would be shown if a link or relationship existed with another entity which could ultimately allow that second entity the opportunity to direct or exercise the health planning and development functions of the HSA.

b. Health Systems Agency of Oklahoma v. Norman, 589 F.2d 486 (10th Cir. 1978).

An unsuccessful competing applicant for designation as an HSA brought an action challenging the HEW Regional Health Administrator's refusal to waive a deadline and accept its application for designation filed 55 minutes late. The Court found the Administrator's action an abuse of discretion and ordered HEW to conduct a new comparative review of plaintiff's and the successful applicant's applications.

2. SHPDAs

a. Opinion of the Justices 381 A.2d 1204 (N.H. 1978)

A State Governor brought an action seeking an advisory opinion from the state Supreme Court as to whether the state constitution, or the Supremacy Clause of the U.S. Constitution, Article VI, and NHPRDA prohibited the state legislature from specifying the agency of state government which the governor should select to be designated as the SHPDA. NHPRDA provides that the SHPDA should be "selected by the Governor." (42 U.S.C.A. §300m(b)(1); Public Health Service Act §1521(b)(1)). The Court answered that: (1) the state constitution permits the legislature to confer civil offices, except for agencies established by the state constitution, and the legislature may designate the agency to be the SHPDA because the health planning agency is not of constitutional dimension; and (2) NHPRDA does not prohibit specification of the SHPDA by the legislature because the thrust of the Act is that the state should construct its own administrative plan and designate its own planning agency and the provision of the NHPRDA that the governor select the SHPDA should not be read to exclude state legislature involvement in the selection process.

3. Allowable Costs of Designated HSA's/SHPDA's

a. *Hamilton v. Northeast Kansas Health Systems Agency, Inc.* 701 F.2d 860 (10th Cir. 1983), *rev'g* No. 79-4199 (D. Kan. June 30, 1980, *subs. order and judgement* August 28, 1980)

An HSA attorney brought an action against the HSA seeking money damages for breach of contract for legal services. The attorney had represented the HSA in an unsuccessful action seeking to enjoin DHHS from discontinuing the HSA's designation agreement. The HSA attorney's action was initially brought in state court, where he obtained a confession of judgement against the HSA, and subsequently removed to federal court by the United States as intervenor - defendant.

The Court of Appeals first held that litigants who unsuccessfully prosecute claims against the U.S. may not recover their attorneys' fees from the U.S. (42 U.S.C. §2412) nor from funds in the possession of a federal grantee but in which the government has a reversionary interest. However, the reversionary interest of the U.S. in grant funds to HSAs expires once the funds are lawfully obligated.

The Court next held that the HSA lacked the authority to lawfully obligate federal funds to compensate Hamilton for representing it because: (1) the grant accounting principles applicable to the HSA proscribed the use of federal grant funds for "the prosecution of claims against the Government." (45 CFR Part 74, Subpart Q §74.174 Appendix F, § G(31)(d) (1978) (amended 1980) [made applicable to HSAs by 42 C.F.R. §122.208(a) (1983)]) [*Ed. Note:* The current rules on allowable costs, which contain a similar proscription, are contained in OMB Circular A-122 (*reprinted in* 45 Fed. Reg. 46021 (July 8, 1980) which is incorporated by reference in the current version of 45 C.F.R. §74.174 (1983)]. The Court held that this proscription extended to any type of legal action against the United States, not just actions for money damages as the district court had concluded; and (2) the federal health planning regulations relating to HSAs which provide that if necessary for the performance of its functiosn an HSA may employ consultants and may contract with individuals and entities for the provisions of services (42 C.F.R. §122.111(a) (1983)), only authorizes expenditures for legal services incidental to the day-to-day activities of a health systems agency not for challenges to DHHS actions.

G. PUBLIC/PRIVATE STATUS AND FUNCTION OF HSAs

1. _Cf_. _Simon v. Cameron_ 337 F.Supp. 1380 (C.D.Ca. 1970)

   A convalescent hospital which had been denied a license brought an action challenging the constitutionality of a statutory provision requiring approval by the state and local Comprehensive Health Planning agencies as a condition of licensure. The Court held that the local voluntary health planning agencies (so-called 314(b) agencies established pursuant to P.L. 89-749, the "Comprehensive Health Planning and Public Health Services Amendments of 1966") which were financed by federal funds and authorized by state law to carry out various health planning functions including reviewing individual proposals for construction of new health facilities for need and desirability (subject to further review by a council appointed by the Governor and Legislature) were public agencies because of their close connection with the state.

2. _American Medical International, Inc. v. State Health Planning Advisory Council_ No. 165724 (Az.Super.Ct. Pima County February 1, 1979)

   A hospital brought an action to, among other things, compel an HSA to deem its application for a CON to construct a hospital complete and to grant it a hearing on the application. In reviewing this claim the Court held that the state APA did not apply to the HSA because the HSA was not a state agency.

3. _Montgomery County, Maryland v. Califano_ 449 F.Supp. 1230 (D.Md. 1978), _aff'd_ 599 F.2d 1048 (4th Cir. 1979)

   A county brought an action challenging the regulations under NHPRDA which provided that if the governing board of an HSA is a public regional planning body or unit of local government the authority to perform the health planning functions within the HSA resided in the so-called "governing body for health planning" of the HSA, _not_ the public regional planning body or the unit of local government (42 CFR §122.109(d) (1977)). The Court held that the regulation exceeded statutory authority in depriving the public regional planning body or unit of local government of its authority to control the "governing body for health planning" in the performance of its health planning functions. [The 1979 Amendments to the Act added a provision which in effect reinstated the provision in Sec. 122.109(d) held invalid in this case. (See Public Health Service Act §1512(b)(3)(B)(ii), 42 USCA §300l-1(b)(3)(B)(ii)) - Ed.]

4. Munchak v. HSA of Northeast Pa., Inc. No. 80-0752 (M.D. Pa. Dec. 1, 1980)

   Plaintiff brought an action challenging actions of the HSA in connection with its review of a project involving merger of two hospitals. In declining review the Court noted briefly in dicta that the HSA was not a federal agency.

5. Finger Lakes Health Systems Agency v. St. Joseph's Hospital 412 N.Y.S. 2d 419 (App.Div. 1981)

   An HSA brought an action to enjoin a hospital, a professional corporation of radiologists, and others from constructing a building and acquiring and installing a CT scanner in the building without first obtaining a certificate of need. In dismissing the HSA's action on the grounds that the agency lacked standing to bring the action, the Court ruled that the function of the HSA, which is established to oversee and control health care services within its designated area, is primarily advisory to the state Commissioner of Health.

6. National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City 452 U.S. 378 (1981)

   A corporation proposing to construct a new hospital brought an action against the local and national Blue Cross Association alleging that the refusal of Blue Cross to accept the new hospital as a participating member in its health insurance plan violated federal antitrust laws. The Supreme Court held that the action of Blue Cross was not immune from antitrust liability on the basis of an implied repeal of the antitrust laws by NHPRDA. The Court rejected Blue Cross' argument that its conduct was immunized because it was taken in response to a finding of excess hospital bed capacity in the area by the local HSA. In the course of doing so, the Court observed that the local HSA was a private, advisory planning body, not a governmental entity, and that HSAs under NHPRDA did not possess regulatory authority over health care providers.

7. Hicks v. Southern Maryland Health Systems Agency No. R-80-2980 (U.S.D.C., D.Md. March 8, 1983)

   Ex-employees of an HSA brought an action against the HSA and its Executive Director and the federal, state, and local governments alleging wrongful or discriminatory discharge in violation of rights protected under the First, Fifth, and Fourteenth Amendments; Title VI and VII of the Civil Rights Act; NHPRDA; and various other federal and state laws. The HSA was a "public regional planning body-type" HSA (See 42 C.F.R. §122.102(b)) established by four counties pursuant to a state statutory authorization. It had a governing board comprised of local government officials and a separate governing body, selected in accordance with NHPRDA and federal regulations, with exclusive responsibility for the agency's health planning functions (See 42 C.F.R. §122.109(d)). The plaintiffs were dismissed, in part for breach of an internal policy and for allegedly making false statements adversely affecting the agency's reputation.

The Court dismissed the plaintiff's action, holding, among other things, that plaintiffs failed to demonstrate that the HSA acted "under color of state law" for purposes of their 42 U.S.C. §1983 claim of deprivation of constitutional rights. To support such a showing the plaintiffs would have to demonstrate that the HSA Executive Director was a state actor such that his personnel decisions regarding plaintiffs were chargeable to the state, as indicated by the following tests: (1) the extent and nature of public funding to the HSA; (2) the extent and nature of regulation of the HSA; (3) whether the HSA's activity constituted a public function traditionally the exclusive prerogative of the State; and (4) whether there was a symbiotic relationship between the HSA and the state. The Court held that: (1) although the HSA's governing board was comprised or elected county officials and the HSA was designated a "public regional planning body-type" HSA, it was not an official state agency. The Court noted that: (a) federal regulations prohibited the HSA from being a state agency (42 C.F.R. §122.102(b)); (b) the state, not the HSA, had final authority on CON applications; and (c) the HSA received most of its funding from federal sources but was eligible to receive funds from other sources. (2) None of the four tests for charging HSA personnel decisions to the state were met because: (a) the funding factor was of minimal importance since the HSA was funded primarily by federal not state sources; (b) any link between state regulation of the HSA and the HSA's personnel policies pursuant to which plaintiffs were discharged was weak; (c) the state had not traditionally preempted the private sector's role in providing health care planning, and therefore the function of day-to-day personnel administration in private health planning agencies was not a public function preempted by the State; and (d) no symbiotic relationship existed between the HSA and the State because plaintiffs had not shown that the state profited from their termination.

The Court also held that plaintiffs failed to demonstrate that their discharge was federal action giving rise to a

Fifth Amendment due process cause of action because: (1) the HSA was not an official agency of the federal government (citing National Gerimedical and Women's Community Health Center; and (2) although the federal government extensively regulated the HSA, the regulation was directed primarily to oversight and funding supervision and not to day-to-day functioning of the agency, including internal employment procedures and the internal policy directive whose violation led to plaintiffs' dismissal.

8. Robinson v. Houston-Galveston Area Council 566 F. Supp. 370 (S.D. Tex. 1983)

Ex-members of the "governing body for health planning" (GBHP) of a public regional planning body HSA (H-GAC) brought an action seeking reinstatement on the GBHP and nominal damages. H-GAC was a Regional Planning Commission composed of elected officials created and organized under state law. At the times relevant to this case it was an HSA of the public regional planning body type. In the course of ruling for plaintiffs the Court held that H-GAC was a political subdivision of the state and as such was bound by the fourteenth amendment.

9. Garst v. Stoco 604 F.Supp. 326 (E.D. Ark. 1985)

A disapproved CON applicant brought an action against a hospital and associated persons alleging, among other things, a conspiracy in violation of federal and state antitrust laws to monopolize and exclude it from the local birthing center market. Plaintiff's application for a four-bed, non-hospital birthing center had been disapproved by the SHPDA following a negative recommendation by the local non-profit HSA. The hospital (which planned a similar project) and other defendants actively opposed the application before the HSA including writing letters, meeting with HSA members, soliciting others to write letters, circulating petitions, and soliciting attendance at the HSA hearing on the application. The defendants argued that they were protected from antitrust liability for such actions by the Noerr-Pennington doctrine. The Court agreed, holding that: (1) The HSA was a government body with respect to its recommendations concerning certificate of need and defendants' opposition to the application before the HSA was protected by Noerr-Pennington even if motivated solely by anti-competitive intent.

H. STATE/FEDERAL STATUS OF DPAs

1. Wilmington United Neighborhoods v. U.S. 615 F.2d 112 (3rd Cir. 1980), cert. denied 449 U.S. 827 (1980)

Consumers of medical services brought an action seeking judicial review of a DPA decision approving for reimbursement under Section 1122 a project to relocate hospital services from the inner city to the suburbs. The Court held that Section 1122(f) impliedly precluded judicial review by federal courts of DPA determinations because: (1) the Section 1122 program is not a "federal" program requiring federal court intervention to assure uniform interpretation and application of federal regulations, and (2) federal judicial review would interfere with the autonomy or authority of state and local health planning agencies.

2. Heritage Regency Inc. v. State Board of Health of Indiana as the Designated Planning Agency No. C-80-9441-C (Indiana Cir.Ct. County May 21, 1981)

   A hospital brought an action seeking judicial review of a DPA decision making findings recommending denial of reimbursement under Section 1122 for a "comprehensive care" (nursing care) facility. The state argued that judicial review of its decision was not available under the state Administrative Procedures Act because the Board of Health was not acting as a state agency when it performed the functions of a DPA. The Court held that the DPA was a state agency because, in addition to carrying out responsibilities under its Section 1122 contractual agreement with the federal government, it was carrying out a public responsibility for more effective health planning and advancing the interests of the state and its citizens in general as well as the interests of individual Medicare participants who derive direct financial benefit from the program.

3. Greenbriar Convalescent Center, Inc. v. Dept. of Public Health 310 N.W.2d 812 (Mich.App. 1981)

   A nursing home brought an action seeking judicial review of a DPA decision that its proposed construction project did not fall within the Secion 1122 grandfather exemption. Review was sought under a state statute providing for judicial review of state agency "rulings" as to the applicability of a statute "administered by the agency" to an actual state of facts. The Court held that a DPA determination of non-exemption from the Section 1122 review process was not reviewable under the state statute because: (1) the federal 1122 regulations do not expressly provide for judicial review of determinations of non-exemption, instead providing that such determinations may be appealed to the Secretary of HHS (42 C.F.R. §100.103(d)), and where the federal regulations intend to make provision for state judicial review of DPA determinations they do so explicitly. [See e.g., 42 C.F.R. §100.106(c)(4), which permits state court review of DPA determinations on the merits of proposed capital expenditures]. (2) Section 1122 review is a federal program administered by DHHS. Although the DPA has a contractual role in the program, it is not "administered" by the DPA, and therefore its determinations of non-exemption are not covered by the state judicial review statute. (3) Citing Palmetto General Hospital Inc. v. State Department of Health and Rehabilitative Services, the Court also observed that in the absence of authorization for state court judicial review in the federal 1122 statute or regulations it was extremely doubtful whether the Secretary of DHHS would be bound to follow a state court judgment.

4. Mallard Associates v. Commonwealth Department of Public Health 439 A.2d 866 (Pa.Cmwlth. 1982) ("Mallard II")

   A nursing home brought an action seeking review by way of a writ of mandamus of a hearing officer's affirmance of a DPA decision recommending denial of reimbursement under Section 1122 of the nursing home's project to construct a new facility. The Commonwealth Court had original jurisdiction in actions of mandamus to review ministerial, non-discretionary acts of state agencies. The Court denied the writ, holding that it lacked jurisdiction because: (1) the hearing officer, being a creature of federal statute and regulation, was neither an officer nor an agency of the state; and (2) petitioner's action sought review of discretionary, not ministerial, acts.

I. SHPDA/DPA ORGANIZATION/ADMINISTRATION

1. Van Pelt v. Wallace No. 83-H-159-N (U.S.D.C., M.D.Ala. April 28, 1983)

   An individual brought an action seeking to enjoin the state governor from terminating the individual's term of office on the SHPDA, which under the state CON statute was a nine-member board consisting of "three consumers, three providers, and three representatives of the governor who shall all serve staggered terms and all be appointed by the governor." Plaintiff had been appointed by the previous governor. The Court held that the new governor's termination of the plaintiff did not constitute an actionable deprivation of a protected property interest because the language of the CON statute, and in particular the reference to "staggered terms," could not be construed as creating any vested right in any appointee for a specified term.

J. HSA/SHCC NHPRDA IMMUNITY PROVISION

1. Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield of South Carolina, Inc. and Palmetto-Lowcountry Health Systems Agency C/A No. 81-1639-1 (D.S.C. Nov. 2, 1982), 1983-2 Trade Cas. (CCH) ¶65,674

Several physician groups who performed CT scanning in non-institutional settings brought an action against BC/BS and a HSA alleging a conspiracy to exclude them from the market in violation of federal and state antitrust statutes. They asked for damages and injunctive relief. Since 1977, BC/BS had denied reimbursement for CT scanning not operated by a hospital nor approved by a health planning agency. In 1979 an HSA study of CT scanning recommended that scanners be located only in hospitals and that all third-party payors deny reimbursement for scans performed by CT scanners for which no CON had been obtained.

The Court granted a summary judgement for the HSA, holding that it was exempt or immune from antitrust liability under several alternate grounds. The Court held that the HSA was immune from liability pursuant to the express immunity clause of NHPRDA (Public Health Service Act §1512(b)(4), 42 U.S.C.A. §3001-1(b)(4)), which provides that an HSA shall not, by reason of the performance of any duty, function, or activity required of or authorized to be undertaken by the agency, be liable for damages under any federal or state law if the HSA employee or governing body member acting for the agency acted within the scope of his duty, function, or activity, exercised due care, and acted without malice toward any person affected, because the HSA CT scanning study was undertaken to comply with NHPRDA [see Public Health Service Act §1513(b)(2) which requires HSAs to give "appropriate consideration" to the National Guidelines for Health Planning and to adopt an HSP which "takes into account" the health resources supply and distribution standards in the Guidelines - Ed.] and to comply with the regulatory requirement that the HSA analyze the needs and conditions in its health service area and apply the National Guidelines for Health Planning, including the guidelines for CT scanners, in the development of its HSP (42 C.F.R. §121.5 (1978)).

2. DeSoto Medical Center, Inc. v. Methodist Hospitals of Memphis 604 F.Supp. 307 (S.D. Miss. 1985)

A disapproved CON applicant brought an action against competitor hospitals, the HSA, the state CON agency, and others alleging a conspiracy in violation of federal antitrust laws to exclude it from the local hospital market by preventing it from obtaining a CON. The complaint alleged that both HSA and state agency officials or employees acted in bad faith contravention of their own regulations and guidelines in the course of denying the CON. The Court denied a motion to dismiss or for summary judgment filed by the HSA, holding that although NHPRDA grants limited immunity from liability for damages to HSAs [Public Health Service Act §1512(b)(4)(A)(i); 42 U.S.C.A. §3001-1(b)(4)(A)(i)] the HSA was taken out of the immunity clause's protection by the hospital's allegations against it of bad faith conduct by HSA officials/employees outside the scope of their duties, as to which the HSA had failed to show that there was no genuine issue of material fact.

II. CERTIFICATE OF NEED AND 1122: COVERAGE, EXEMPTIONS, AND ENFORCEMENT

A. INDIVIDUALS AND ENTITIES SUBJECT TO CON REGULATION

1. Physician group practice

a. State v. Mitchell 321 N.Y.S.2d 756 (Sup.Ct. Niagara Cty. 1971)

The State Health Department brought an action to enjoin the defendant from operating an "abortion referral service" without obtaining a license and a CON as an "independent out-of-hospital health facility." The defendant was a non-physician who proposed to establish a business which would advertise the availability of and provide transportation to a location at which physicians, who would sublease space from the defendant for operating and recovery rooms, would perform abortions. The Court held that defendant was operating an "independent out-of-hospital health facility," not merely a physicians' office as defendant contended because: (1) defendant and other non-physicians had the primary role in operating the business and contacting patients (precluding genuine doctor-patient relationships); and (2) defendant was splitting fees with the physicians.

b. People v. Dobbs Ferry Medical Pavilion 340 N.Y.S. 2d 108 (App. Div. 1973), aff'd, 347 N.Y.S. 2d 452 (Ct. App. 1973)

The State Health Department brought an action to enjoin a partnership of three physicians from operating a practice primarily devoted to the performance of abortions without obtaining a license as an "independent out-of-hospital health facility." This was a type of hospital defined in state regulations as an "institution with one or more health clinics not part of an inpatient health facility... which is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician." The physicians defended their actions on the grounds that the statute and regulations were unconstitutionally vague and overbroad and that in any case their practice did not constitute an "independent out-of-hospital health facility." The Appellate Division held for the physicians on both grounds; the Court of Appeals affirmed on the constitutional issue, not reaching the second issue. On the second issue the Appellate Division had concluded that the physicians were merely a partnership engaged in a specialized group practice, basing its opinion on the fact that the practice of the three doctors came squarely within a definition of "group practice" advanced by the AMA. It rejected the trial court's contrary conclusion that the physicians were operating an institution, based on evidence of the high volume of their business, the size of their income, the preponderance of abortions in their practice, their regular working hours, and a seeming lack of personal contact between patient and doctor.

c. *Cf. Extendicare, Inc. v. State Coordinating Council for Health Planning* 532 P.2d 1119 (Kan. 1975)

An individual physician and a professional physicians' corporation brought an action appealing the decision of the Council denying them standing to appeal to the Council the granting of a CON to a hospital to expand its facility. The CON statute granted standing to appeal to applicants and "health facilities" -- defined in the CON statute as "any health or medical facility that is licensed" by the state. The Court held that the physician and professional corporation lacked standing because, viewing the statute in its entirety, it was apparent that the legislature did not intend individual physicians or professional corporations of physicians to be embraced within the term "health facility."

d. *Connecticut Commission on Hospitals and Health Care v. Neurodiagnostics* No. 143812 (Conn. Ct. C.P. Hartford County, Dec. 20, 1977)

A state agency brought an action seeking to enjoin a professional corporation of physicians from acquiring a CT scanner without first obtaining a CON. The Court held that the state CON statute subjecting "health care facilities and institutions" to regulation did not apply to the physician corporation because: (1) the terms "facility" and "institution" do not include physician corporations; (2) the legislative history does not indicate an intent to apply to physicians' offices; and (3) if the statute were interpreted to apply to physician corporations it would be unconstitutional on the grounds of vagueness and lack of substantive rationality.

e. *Marsh v. Finley* 389 A.2d 490 (N.J. Super. Ct. App.Div. 1978), *cert. den.*, 78 N.J. 396 (N.J. 1978)

A physician brought an action appealing the order of the state Commissioner of Health requiring him to obtain a CON before acquiring a CT scanner to be used in his office. The Court held that the certificate of need statute subjecting "health care facilities" to regulation did not apply to a physician doing business as a professional association who seeks to acquire a CT scanner to be located in his private office because: (1) the statutory language and legislative history clearly evince the objective of control over institutions, not private practices, and (2) even with the addition of a CT scanner the physician's office remains essentially a private practice.

f. Peck v. Whalen No. 1597179 (N.Y. Sup.Ct. Westchester County March 21, 1980)

A physician partnership brought an action challenging an order of the SHPDA directed at them and at a hospital requiring the hospital and the partnership to cease operating a CT scanner without obtaining a CON. The physician partnership had leased office space from the hospital and installed a CT scanner on the leased premises. The Court ordered the SHPDA not to proceed against the partnership but permitted it to proceed against the hospital because the state CON law provided the state with authority to bring the action against the hospital but did not provide the agency with authority to regulate or control persons, such as the physician partnership, who contract with hospitals.

g. Women's Medical Center at Howell v. Finley 469 A.2d 65 (N.J. Super. App. Div. 1983)

Several medical office management corporations brought actions seeking a declaratory judgment that the first-trimester abortion/gyn. group practices operating within their offices (which were offered to the public under the name "Women's Centers" or similar names using the word "Center") were exempt from coverage as "health care facilities" under the state CON/licensure statute. The statute excluded from the definition of covered health care facilities "services provided by a physician in his private practice." State agency regulations did not further define this exemption, but set forth several criteria for determining whether a form of health care delivery constituted operation of a health facility, including type of service and system impact, cost to payors/consumers, degree of technical complexity, referral patterns, and arrangements for payment or reimbursement. The group practices had entered into contracts with the management corporations for pre-packaged office set-up, including administrative, management, billing, office space, equipment, supplies and non-professional services. Patient fees were paid to the management corporations. The physicians were not management corporation employees; non-professional personnel were. The group practices owned the patient records. The state health commissioner concluded that the centers were covered health care facilities because of the strong management role of corporations, the risk that the business relationship between the physicians and the corporations might affect the physicians' medical judgment, and the "facility terms" of the centers' advertisements. Apparently viewing the issue as whether the medical group practices, not the centers or the corporations, were covered health care facilities, the Court reversed. First, it observed that the state CON/facility licensure statute was intended primarily if not exclusively to contain the escalating costs of institutional delivery of health care and the private-practice exemption was based on the legislative perception that institutional cost factors were not relevant to the private practice of medicine. Second, the Court held that the medical group practices were exempt from coverage as health care facilities under the "private practice" exemption because: (1) the nature of the business and administrative management of a medical practice, including whether the management was "in-house" or "out-of-house", were not relevant factors in determing the character of the practice as long as the manner of their performance did not impinge upon the ordinary patient-private physician relationship and did not impinge upon professional control by the physicians of the medical practice and did not affect the essential character and commonly understood attributes of private practice; and (2) the health commissioner's concern for potential ethical problems resulting from the group practice-management corporation business relationship were properly matters for the Board of Medical Examiners and were not primarily within the regulatory or adjudicatory jurisdiction of the Commissioner.

2. Medical Equipment Leasing Corporation

a. Finger Lakes Health Systems Agency v. St. Joseph's Hospital 412 N.Y.S. 2d 419 (App.Div. 1981)

A State Attorney General brought an action to enjoin a hospital, a professional corporation of radiologists, a medical equipment leasing corporation, and others from constructing an addition to the hospital and installing a CT scanner in it without first obtaining a CON. The hospital built a medical office building adjacent to its facility (and connected to it by a covered walkway) and leased space in the building to the professional corporation of radiologists. They installed the CT scanner in the leased space, contracted with the hospital for technicians to assist in operating the scanner, and provided scanning services to hospital and non-hospital patients. The CT scanner was owned by the medical equipment leasing company and leased to the professional corporation of radiologists. The Court dismissed the action as to the medical equipment leasing corporation because, their involvement being limited to acquiring the scanner and leasing it to the radiologists, they were parties who merely contracted with an entity subject to CON regulation and therefore they were not subject to control under the CON statute.

3. Medical Office Building

a. Cf. Finger Lakes Health Systems Agency v. St. Joseph's Hospital No. 2520-79 (N.Y. Sup. Ct. Chemung County June 20, 1980), aff'd, 412 N.Y.S.2d 419 (App.Div. 1981)

An HSA and the State Attorney General brought actions to enjoin a hospital, a professional corporation of radiologists, and others from constructing an addition to the hospital and installing a CT scanner in the addition without obtaining a CON. The hospital constructed a medical office building adjacent to its facility (and connected to it by an enclosed walkway) and leased space in the building to the professional corporation of radiologists. They installed the CT scanner in the leased space, contracted with the hospital for technicians to assist in operating the scanner, and provided scanning services to hospital and non-hospital patients. The Appellate Division dismissed the HSA's action for lack of standing and the Attorney General's action on the grounds that the balance of hardship between the state and the defendants weighed against enjoining the scanner where it was already in operation and no public harm from its operation was demonstrated. The lower court opinion, not adopted by the Appellate Division, had reached the merits as to the hospital defendant and held that the hospital did not acquire a CT scanner without a CON in violation of the state CON statute because: (1) the hospital did not own or lease the scanner; (2) the hospital did not maintain or exercise control over the scanner, having merely a contractual relationship with the radiological group; and (3) the scanner was located in a building (the medical office building) which was not a "hospital" and therefore not subject to regulation under the CON statute.

4. Energy Plant

a. Town of Brookline v. Medical Area Service Corporation 392 N.E. 2d 1070 (Mass. App. 1979)

A taxpayer group brought an action to enjoin the construction without first obtaining a CON of an energy plant designed to provide power to several health care facilities. The plant would be constructed and owned by a bank affiliate, leased to Medical Area Service Corporation (MASCO) (some of whose members were hospitals) to meet the members' energy requirements, and ultimately would be subject to an option to purchase by a non-hospital MASCO member. The state CON statute subjected "health care facilities" and any part thereof to regulation. The Court concluded that the plant lacked the "substantial nexus" to the MASCO member health care facilities necessary to bring it within CON coverage, because the plant would not be physically located in a health care facility, would provide services to non-health care facilities, and would not be owned by, leased to, financed by, or ultimately subject to purchase by, a health care facility.

b. Cf. Town of Brookline v. Gorsuch 667 F.2d 215 (1981)

A town brought an action seeking judicial review of an EPA determination that diesel engines proposed to be installed in an energy plant owned by a corporate subsidiary of a university were exempt from certain provisions of the Clean Air Act because the plant was an exempt "health or education institution." The plant provided energy primarily to university medical and health-related schools and several nearby hospitals. A state court had earlier ruled that the energy plant was not a covered "health care facility" under the state CON statute (Town of Brookline v. Medical Area Service Corporation) and the town argued that the plant was not a health institution within the meaning of the federal Clean Air Act. The Court upheld the EPA decision because: (1) though not itself a school or hospital the energy plant served the purpose of providing energy for health or education institutions; (2) the plant was owned and operated for the benefit of health or education institutions; and (3) although this factor alone would not suffice to bring the plant within the definition of a health institution, the plant furthered the stated purposes of NHPRDA of giving priority consideration to development of multi-institutional arrangements and to energy conservation for health care institutions. (Public Health Service Act §1502(a)(5), (11); 42 U.S.C.A. §300k-2(a)(5), (11)). The Court also indicated that even assuming the state law determination that the energy plant was not a healthcare facility should be given weight, the term "health or education institution" in the Clean Air Act was much broader.

5. Mobile Multiphasic Testing Service

a. Madcor, Inc. v. Finley 430 A.2d 964 (N.J. Super. App. Div. 1981)

A mobile multiphasic health testing service which offered automated testing using mobile vans carrying medical screening equipment brought an action seeking judicial review of a state agency determination that it was subject to CON regulation. The state statute subjected "health care facilities" providing "health care services" to CON regulation. The Court held that the mobile testing service was subject to regulation because: (1) it was within the statutory definition of a health care facility ("a facility or institution...engaged principally in providing services for...diagnosis or treatment of human disease...."); and (2) the state CON regulations included mobile multiphasic health testing services in their list of standard categories of health care services.

6. *Component of Larger Facility*

a. *South Central Health Planning and Development Center, Inc. v. Commissioner* 628 P.2d 551 (Alaska 1981)

An HSA brought an action to enjoin construction of a skilled nursing unit within a home for the aged on the grounds that the facility had failed to submit the project to CON review. The Court held that the state CON statute subjecting "skilled nursing facilities" to regulation covered a skilled nursing facility to be added to a larger, otherwise non-covered institution because: (1) such facilities are required by NHPRDA to be covered by a complying state CON statute (42 CFR §100.102(e)(4), *made applicable by* Section 1531(5), 42 U.S.C.A. §300n(5)); and (2) the purposes of a CON statute (preventing unnecessary duplication of health resources) are as applicable to them as to free-standing skilled nursing facilities.

7. *Facility Not Accepting Public Funds*

a. *Baird v. Axelrod* 477 N.Y.S.2d 845 (App. Div. 1984)

A nursing home brought an action seeking judicial review of a state agency decision denying its application to add two beds. The nursing home, which did not participate in Medicaid and did not accept public funds, alleged, among other things, that the state agency lacked jurisdiction over it and other health care facilities that did not accept public funds. The Court rejected the nursing home's claim, holding that the state had the authority to regulate the nursing home because the state CON statute, which conditioned approval of public and private facility projects on a finding of public need, made no distinction between hospitals that received public funding and those that did not.

B. PROJECTS SUBJECT TO REVIEW

1. *Projects commenced or acquired before effective date*

a. Section 1122 Cases

(1) *Cf.* *Sisters of Charity Hospital of Buffalo v. Blue Cross Assoc./Blue Cross of Western New York, Inc.* PRRB Hearing Dec. No. 79-D51 (Aug. 10, 1979) [1979 Transfer Binder] MEDICARE AND MEDICAID GUIDE ¶30,067

A hospital administratively appealed an intermediary decision denying reimbursement for depreciation expenses associated with a bridge and walkway connecting it to an adjacent medical office building. The intermediary found the costs non-reimbursable because the hospital had failed to obtain

1122 approval. The PRRB ruled that the depreciation expenses were reimbursable because: (1) Section 1122 regulations exempted from review capital expenditures the obligation for which was incurred prior to December 31,1972, or the effective date of the Section 1122 agreement between the Secretary of HHS and a state, whichever is later; (2) the state 1122 agreement was effective February 28, 1974; and (3) although the actual construction contract for the bridge and walkway was not signed until April 1974, the obligation was established before then (the owner-architect agreement was dated December 10, 1973, preliminary work began in December 1973, and prior to February 28, 1974 the hospital contacted the appropriate planning council and learned that project approval was unnecessary).

(2) Humana Medical Corporation v. Schweiker No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. On November 24, 1970 the hospital had acquired an adjacent facility with a view toward expanding its existing plant. On December 21, 1972 it applied for a CON for a 55 bed expansion/renovation project on the site. On December 29 or 30, 1972 the hospital poured a concrete footing for a construction project on the site. On April 15, 1973 it received a CON for the project, valid for six months and showing an estimated cost of $750K. On Sept. 26, 1973 it entered into a construction contract for Phase I of the project. Following completion of Phase I the hospital entered into a contract for Phase II on July 1, 1974 at a stated cost of $1.6M. Phase II was completed in July 1976 at a total project cost of $3.3M.

On October 30, 1972 Congress had passed P.L. 92-603, which adopted the Section 1122 program and which contained a provision (the so-called "221(b) effective date") stating that the Section 1122 program would apply only with respect to capital expenditures incurred subsequent to the earlier of December 31, 1972 or the last day of the calendar quarter in which a State requested that the program apply (P.L. 92-603 §221(b) not codified; See 42 U.S.C.A. §1320a-1 Historical Note). Federal regulations provide for coverage under Section 1122 of capital expenditures incurred after December 31, 1972 or the effective date of a DPA Agreement, whichever is later, and permit the Agreement's effective date to be earlier than its signing date if DPA procedures utilized as of the earlier date satisfy DHHS (42 CFR §100.103). The Alabama DPA issued an 1122 Procedures Manual effective September 18, 1973 and on February 27, 1974 the state entered into a DPA Agreement with DHHS, antedated to

Sept. 18, 1973, eight days before the hospital's Phase I contract.

In late 1976 Medicare fiscal intermediary auditors warned the hospital that under Section 1122 it would not be able to receive reimbursement for capital costs associated with the costs in excess of the amount on the April 1973 CON for the project without DPA approval. In response the hospital applied for and received DPA approval on March 21, 1977 of the costs in excess of $750K. In January 1977 DHHS had issued a Policy on Lack of Timely Notice (Section 1122 Notice 77-01; 42 Fed. Reg. 4847 (January 26, 1977); 42 CFR §100.108 Note (1981)) providing that when a person neglects to submit an 1122 application within 60 days prior to incurring a capital expenditure as required by Section 1122 DHHS will withhold reimbursement for one year. Pursuant to the policy, at the DPA's recommendation the Secretary of DHHS decided to exclude reimbursement for one year on the costs in excess of the amount on the original CON. The hospital requested and was denied a fair hearing on the one-year exclusion by the DPA. When the fiscal intermediary denied reimbursement on account of the DHHS exclusion, the hospital appealed the denial to the PRRB (the Medicare administrative appeals board) and, following the PRRB's refusal to take jurisdiction on the question of the propriety of the Secretary's exclusion, brought this action.

The hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc. which are treated elsewhere in the GUIDE. On the effective date issues the Court held as follows: (1) The hospital asserted that the obligation for all the capital expenditures associated with the project was incurred on Sept. 26, 1973, when the Phase I contract was signed, and that the DPA lacked authority to conduct an 1122 program on that date because, although the DPA Agreement was later antedated to September 18, 1973, there was no signed DPA Agreement on September 26. The Court rejected this argument, holding that: (a) as long as the DPA satisfied 1122 requirements and the hospital was actually notified of the state's inception of 1122 review, antedating the DPA Agreement pursuant to 42 CFR §100.103 was not improper because the signing of a DPA Agreement was not an authorization to set up an 1122 program but rather an approval that all requirements had been met, all procedures were in place, and review of capital expenditures was proceeding according to the statute; and (b) the "221(b) effective date provision" did not require dating the DPA Agreement on the last date of the calendar quarter in which the Agreement was signed because 221(b) only operated to set the effective date for states which sought to implement 1122 prior to December 31, 1972; and (c) 42 CFR §100.103, which sets the effective date of 1122 programs entered into after December 31, 1972, was not arbitrary, capricious or an abuse of discretion. (2) The project was not exempt on the grounds that construction began in December 1972 before the effective dates of the federal 1122 statute and the state program because the pouring of the concrete footing could not be construed as a start of construction (particularly where the hospital changed the architect and general contractor between then and the Phase I contract) but rather as a sham performed in an attempt to avoid the 1122 requirements.

b. CON Cases

(1) City of La Moure v. State Health Council 213 N.W. 2d 869 (N.D.1973)

A hospital brought an action seeking a ruling that its construction project was exempt from CON. The statute contained a grandfather clause and an effective date provision. The Court held that although the project was not exempted under the terms of the grandfather clause, it was exempt because proposed and commenced before the effective date.

(2) Cf. Health Resources Foundation v. Dept. of Health 377 N.E.2d 1056 (Ill.App. 1978)

A hospital brought an action seeking: (1) judicial review of the decision of the Department of Health denying it a license to establish a new hospital; and (2) a declaratory judgment that the state CON statute did not apply to it. Plaintiff's application for a license for the new facility had been pending for several months before and after the effective date of the state CON statute. A grandfather clause exempted from CON only those projects for which final construction plans were approved (the last step required to obtain a hospital license) before the effective date. The trial court ordered a license issued (for reasons unrelated to this discussion). Because it concluded that equity required exempting plaintiff from CON when the delay in issuance of a license was largely the fault of the state, the trial court back-dated its order to a date prior to the effective date of the CON statute, in effect granting plaintiff a non-statutory, equitable exemption from CON. The appellate court reversed, holding that the project did not meet the requirements for a grandfather exemption set forth in the CON law, and the effect of the order exempting the project from review would be directly contrary to the legislative purpose of preventing unnecessary construction.

(3) Pacific Hospital of Long Beach v. Lackner 90 Cal.App.3d 294, 153 Cal.Rptr. 182 (1979)

A hospital brought an action seeking a declaratory judgment that the state CON statute did not apply to its CT scanner acquisition. The statute's effective date was Sept. 9,

1976. On August 5, 1976, the hospital entered into a mutually terminable agreement with the scanner supplier in which the hospital agreed to install and operate the scanner dividing the profits with the supplier for seven years. The Court held the scanner acquisition not subject to CON because the hospital acquired the scanner on August 5 when it entered into an enforceable agreement to acquire it.

(4) Schatzman v. Department of Health and Rehabilitative Services ("In re King Memorial Hospital II") 19 B.R. 885 (U.S. Bankruptcy Ct. S.D. Fla. 1982)

A trustee in bankruptcy brought an action seeking an order declaring it the possessor of a CON exemption for a project to construct a 126-bed facility. The factual background of this case is described in the annotation to Schatzman v. Dept. of Health and Rehabilitative Services ("In re King Memorial Hospital I"), supra p. 41.

The Court held that it had jurisdiction over the subject matter of the proceeding and that, the debtor having filed a petition under Ch. XI, the case was subject to the U.S. Bankruptcy Code. Concluding that DHRS properly set forth the requirements for preserving a CON exemption, e.g. that the project be under physical and continuous construction pursuant to DHRS-approved final construction plans by July 1, 1979, the Court first held that the King project met the requirements because: (1) King met the "physical and continuous construction prior to July 1, 1979" requirement based on the facts that it had hired an architect and engineer, the construction site was levelled and prepared, a survey was taken, and a permit for foundation work was obtained by the building contractor prior to that date; and (2) the June 25, 1979 DHRS approval for commencement of foundation work was sufficient grounds for King to meet the requirement of "construction pursuant to final construction plans."

Second, the Court held that: (1) it was not unreasonable for DHRS to require that the project maintain continuous construction activity after July 1, 1979 to continue to preserve its CON exemption, since otherwise a project could appear to commence construction prior to July 1, 1979 and then not in good faith go forward with actual construction, thereby frustrating the intent of the legislature to repeal the grandfather exemption; and (2) King met the "continuous construction" requirement because: (a) continuous construction through July 31 was evinced by DHRS approval of schematic plans on that date; (b) the requirement was then met through August 15 by King pursuing financing arrangements for the project; and (c) from August 15 to October 2, 1979 the requirement was met by the fact that although DHRS had the opportunity to do so, it did not commence an administrative complaint during this time.

Then, the filing by King of a Petition in Bankruptcy on October 2, 1979 effectively prevented continuation of construction and stayed any further proceedings the purpose of which would be forfeiture of the CON exemption. See "In re King Memorial Hospital I", supra.

The Court also held that DHRS was equitably estopped from acting to forfeit King's CON exemption either because King failed to commence the project prior to July 1, 1979 or because King did not undertake continuous construction thereafter. The action of DHRS working with and cooperating with King in approving the plans for construction five days prior to the July 1 deadline, together with King entering into a binding construction contract, met the requirements of equitable estoppel regarding commencement of the project. The estoppel argument was also valid with respect to continuous construction since once King commenced construction it would be unfair and unreasonable for DHRS to forfeit the exemption without affording King every reasonable opportunity to build.

2. Acquisition of Major Medical Equipment

a. See generally Finger Lakes HSA v. St. Joseph's Hospital No. 2520-79 (N.Y. Sup. Ct. Chemung County June 20, 1980), aff'd, 422 N.Y.S. 2d 219 (App.Div. 1981)

An HSA and the State Attorney General brought actions to enjoin a hospital, a professional corporation of radiologists, and others from constructing an addition to the hospital and installing a CT scanner in the addition without obtaining a CON. The hospital built a medical office building adjacent to its facility (and connected to it by an enclosed walkway) and leased space in the building to a professional corporation of radiologists. They installed the CT scanner in the leased space, contracted with the hospital for technicians to assist in operating the scanner, and provided scanning services to hospital and non-hospital patients. The Appellate Division dismissed the HSA's action for lack of standing and the Attorney General's action on the equitable basis that the AG had failed to promptly prosecute the action before the defendants finished the building and put the CT scanner into operation. The lower court opinion, not adopted by the Appellate Division, had reached the merits as to the hospital defendant and held that the hospital did not acquire a CT scanner without a CON in violation of the state CON statute because: (1) the hospital did not own or lease the scanner; (2) the hospital did not maintain or exercise control over the scanner, having merely a contractual relationship with the radiological group; and (3) the scanner was located in a building (the medical office building) which was not a "hospital" and therefore not subject to regulation under the CON statute.

3. Offering of a new service/substantial change in services

a. Iowa State Dept. of Health v. Hertko 282 N.W.2d 744 (Iowa 1979)

The State Department of Health and an HSA brought actions to enjoin a hospital from offering an open-heart surgery service without first obtaining a CON. The state CON statute, patterned after 42 CFR §123.404(a)(4) as it stood in 1977, provided for coverage of new institutional health services not offered on a "regular basis" "within" the twelve months preceding the effective date of the statute. The Court held that determining whether a service had been previously offered on a regular basis was not merely a matter of determining whether the service had been offered periodically before but instead required examination of the totality of the service being offered, including consideration of the length of time the service had been offered, recurrence of the service, variations in service, and conformance to professional standards and customs. The Court remanded to a trial court to make such a determination.

b. Texas Health Facilities Commission v. West Texas Home Health Agency 588 S.W.2d 655 (Tex.Civ.App. 1979)

A home health agency brought an action seeking judicial review of a state agency "cease and desist" order issued in an administrative CON enforcement proceeding brought against the HHA by the state agency. The agency alleged that the HHA violated the CON statute by opening six "consultation offices and/or work rooms" in a particular geographical area. The offices consisted of one room with a table, chair, and remote telephone answering service. No medical or other records were kept in the office; no employee manned the office; and no treatment or health care functions were performed in the office. The state CON statute required the HHA to obtain a CON or exemption to: modify an existing facility; convert a structure into a health care facility; or substantially expand a service currently offered, which the state agency had by regulation defined to include establishment of a branch office.

The Court held that: (1) the establishment of the consultation offices did not constitute a "substantial expansion of currently offered services" because the HHA had previously provided home nursing services in the area and operated major administrative offices and smaller branch administrative offices in the area and the consultation offices involved no material or substantial change in the operations of the HHA. The function of the office was to serve as a contact point or place where a patient could make contact with the HHA. The type of services offered or rendered by the HHA remained unchanged after opening the consultation offices. (2) The establishment of the consultation offices did not constitute a "modification of existing facilities" or a "conversion of a structure into a health care facility" because the statutory definition of "health care facility", which included "hospitals", "home health agencies" and other health treatment facilities, could not be read to fit the one room, non-manned contact offices within its terms. (3) The establishment of the consultation offices also did not constitute the "establishment of branch offices" because: (a) were the latter phrase to include such establishments it would exceed the statutory limitation of coverage to "substantial" expansion; and (b) state agency rules exempted HHAs from CON coverage for establishment of branch offices if the HHA had delivered home health services in the area prior to a specified date, and the petitioner HHA had done so.

c. Wing Memorial Hospital v. Dept. of Public Health 410 N.E. 2d 729 (Mass. App. 1980)

A hospital brought an action seeking a declaratory judgment that its establishment of satellite clinics on premises separate and apart from the hospital was not covered by the state CON statute. State law subjected to both CON review and licensure the establishment of a clinic or hospital and subjected to CON a substantial change in services by a health care facility. The statute exempted from the definition of a clinic a "clinic conducted by a hospital", but provided that a hospital license would be issued only for the premises described in a license application. State CON regulations defined a substantial change in services to include "the establishment of a satellite clinic or unit of a facility." The Court held that: (1) the establishment of the clinics was subject to review as a clinic establishment because reading the definitional exemption together with the basic coverage provision led to the conclusion that a hospital-run clinic which is to be situated on premises separate and apart from the hospital must hold an individual license or the parent hospital must obtain an amendment to its license to include the off-premises clinic; and (2) the clinic establishment constituted a substantial change in services under the CON regulations, which were consistent with the legislature purpose of preventing unnecessary health care facility expansion and encouraging proper resource allocation, and which prevented hospitals from bypassing CON when expanding services through the establishment of off-premises clinics.

d. Wausau Hospitals, Inc. v. Dept. of Health and Social Services 291 N.W.2d 602 (Wis.App. 1980)

A hospital brought an action seeking judicial review of state agency declaratory rulings that: (1) the hospital was required to obtain a CON to perform elective open-heart, pump-assisted cardiac surgery in its existing facility either as an offering of a new specialized service or as a substantial change in health services; and (2) the hospital was required to obtain a CON for the same service in its new facility. The hospital had operated a cardiac surgery service in its existing facility for some time but prior to and on July 1, 1977, it had discontinued elective open-heart, pump-assisted cardiac surgery and provided only emergency open-heart, pump-assisted cardiac surgery.

As interpreted by the Court, the state health planning statute contained two CON mechanisms, one covering the provision of specialized services and authorizing decertification (Subchapter III) and another covering various other types of projects not including specialized services (Subchapter II). Subchapter II covered "substantial changes in health services"; Subchapter III did not. Subchapter III defined covered cardiac surgery services as follows:

> Specialized services are specialized facilities, equipment and staff necessary:
> (a) To perform heart catheterization studies or cardiac surgery.

Subchapter III contained a grandfather exemption for services in operation on July 1, 1977.

The Court held that: (1) the hospital was not required to obtain a CON under Subchapter III to reinstitute elective open-heart, pump-assisted cardiac surgery because: (a) the definition of specialized services is dependent on capability of terms of specialized facilities, staff, and equipment, not on the type of medical procedures performed; (b) the hospital does not propose to add facilities, staff, or equipment when it reinstitutes elective cardiac surgery; (c) therefore its cardiac surgery service will remain unchanged (and consequently exempt under the grandfather exemption) after it reinstitutes elective cardiac surgery; and (d) this interpretation does not defeat the statutory purpose because no new capital expenditures or resources have been added and if the service is unneeded it can be decertified; (2) the reinstitution of elective surgery is not covered as a "substantial change in health services" because Subchapter III does not contain a "substantial change" test, but if it did it would concern changes in the objective criteria defining specialized services, i.e., facilities, equipment, and staff, not changes in the type of medical procedures performed; and (3) since the hospital's total cardiac surgery service was exempt from Subchapter III when it was in the existing facility, it was also exempt at its new facility.

e. *See generally*, *Community Psychiatric Centers of Oregon v. Grant* Civ. No. 79-782 (D. Ore. July 8, 1980), *rev'd*, 664 F.2d 1148 (Ninth Cir. 1981)

A competitor brought an action to compel the SHPDA to enforce the CON statute against another hospital which was preparing to open a new psychiatric unit without first obtaining a CON. The District Court concluded that NHPRDA contained an implied cause of action for the benefit of the plaintiff, and reached the merits on the issue of whether the competitor's project was covered under the state CON statute. The Court of Appeals reversed on the implied cause of action issue, mooting the District Court ruling on coverage. The District Court opinion on the coverage issue had concluded that the hospital's new psychiatric unit, created by redistributing beds, adding staff, and reorganizing, was subject to CON as a "new institutional health service" not previously offered on a "regular basis" (as those terms were defined in 42 CFR § 123.404(a) at the time of this litigation and in state law) because: (1) although the hospital had offered some psychiatric services regularly but in a loosely organized, scattered fashion in the past, it had not offered them at the level or volume proposed, and an extensive change in level of services constitutes a "new institutional health service" not previously offered on a "regular basis" (citing Iowa Department of Health v. Hertko); and (2) the list of changes and expenditures defined in 42 CFR §123.404(a) as "new institutional health services" does not constitute the exclusive definition of new services but is merely a list of examples, and therefore projects (such as the drastic expansion and reorganization involved in this case) not within the list but clearly intended by Congress to be covered are also "new institutional health services."

f. Cf. Mercy Hospital v. Commonwealth Dept. of Health 450 A.2d 761 (Pa. Cmwlth. 1982)

A hospital brought an action seeking judicial review of a state agency decision that its project to consolidate ten licensed but unused med/surg beds into a dedicated rehabilitation unit was subject to CON review as an "addition of a health service having an operating expense in excess of [the applicable threshold]." The hospital had appealed the coverage determination to the State Health Facility Hearing Board, an administrative appeals board, which affirmed the Department's decision and dismissed the Hospital's appeal, ruling among other things that: (1) the project constituted a health service addition because the project was not a simple redistribution of beds but rather the addition of rehabilitation beds and new personnel to provide more comprehensive rehabilitation services for longer periods of time than those presently offered; and (2) the "operating expense" which is calculated to determine whether a health service addition exceeds the operating expense threshold does not refer merely to the additional operating expenses resulting directly and solely from the establishment of the new service. [The state agency had taken the position that "operating expense" referred to the total operating expenses associated with the completed unit, regardless of whether any portion of those expenses were expenses of the facility prior to the establishment of the service - Ed.] (In re: Mercy Hospital CN 81-001 (Pa. State Health Facility Board Nov. 13, 1981); 1 S.H.F.H.B. 14 (1981).)

The Court held that the hospital's appeal to it should be quashed as premature because the determination of reviewability was not a final order but rather an inseparable subsidiary aspect of the main cause of action-the Department's CON review of the project-reviewable, if the hospital desired, after the Department's decision on the application.

g. People v. City of Colorado Springs No. 81CV2863 (Colo. Dist.Ct. El Paso County Feb. 17, 1982), aff'd. on other grounds No. 82-CA0463 (Colo.Ct.App. Dec. 16, 1982)

A state agency brought an action seeking to enjoin a hospital from adding a new open heart surgery service without first obtaining a CON and seeking judicial enforcement of a declaratory order of the state CON appeals board, the Health Facilities Review Council (HFRC), that the hospital project was subject to CON review. The state statute covered new institutional health services entailing annual operating costs in excess of $82,200. The state statute and regulations did not define "annual operating costs." The state agency and the hospital presented differing calculations of the cost of the new service; the hospital asserted that it would reduce the number of operations performed in the new service to whatever level necessary to keep the operating costs below the threshold. The trial court denied both forms of relief sought, reaching the merits only on the injunctive relief cause. It held that the state agency had failed to meet its burden of proof to show that the open heart surgery program costs would exceed the threshold, and indicated that under the state CON statute and regulations there was nothing to prohibit the hospital from attempting to circumvent the CON process by reducing the number of procedures performed.

h. Koch v. Southeast Alabama Medical Center 432 So.2d 1309 (Ala.Ct.App. 1983)

A hospital brought an action seeking a declaratory judgement that its project-involving the acquisition of an EKG pressure recorder to be used to enable the facility to perform left heart catheterization procedures (coronary arteriogram and left ventriculogram procedures) by cardiologists in a special procedures room-did not constitute the establishment of a new institutional health service requiring a CON. The state statute covered new institutional health services, defined as "health services which are offered in or through a health care facility or HMO, and which were not offered on a regular basis in or through such health care facility or HMO within the 12-month period prior to the time such services would be offered." The statute defined "to offer" to mean that, "the health care facility...holds itself out as capable of providing, or as having the means for the provision of, specified health services." SHPDA regulations did not further define these terms or the term "cardiac catheterization," but the SHP described cardiac catheterization in general terms which included but were not limited to coronary arteriograms and left ventriculograms by cardiologists. The state agency asserted that the project was covered because coronary arteriograms and left ventriculograms by cardiologists constituted a cardiac catheterization laboratory service, which had not been previously provided in the facility.

The Court held that the project was not covered under the state CON statute because: (1) other procedures within the SHP definition of cardiac catheterization had been performed at the hospital within the previous 12-month period and the record reflected no basis for further categorization of cardiac catheterization with resulting new categories of coronary angiograms and left ventriculograms, since the same facilities and equipment are utilized for these procedures as for the others already performed in the hospital; and (2) although the hospital had not previously provided coronary angiograms and left ventriculograms, it had the means and capability to do so and, as indicated, it is the fact of capability which controls and not whether the capabilities were actually being utilized (citing Wausau Hospitals).

i. Kenley v. Newport News General and Non-Sectarian Hospital Ass'n, Inc. 314 S.E.2d 52 (Va. 1984)

A hospital brought an action seeking a declaratory judgement that it did not need a CON to operate a complete program of open heart surgery. From 1976 onward the hospital offered a limited cardiac surgery program consisting of pacemaker insertions, pulse generator changes, vena cava umbrella insertion, and, until November 11, 1977, pericardiectomies at which a heart-lung bypass machine to perform the functions of circulation during surgery and a perfusionist to operate the machine were available on a standby basis. After that date the perfusionist left the hospital's employment. On Nov. 21, 1978 the State Health Commissioner issued a decision ruling that throughout 1977 to Nov. 1978 the hospital cardiac surgery program consisted of specified procedures which did not include open heart surgery, and that prior to performing open heart surgery services the hospital would be required to obtain a CON. State regulations defined a new service as any service not provided during the preceding twelve months. The Court upheld the Commissioner's decision because following the perfusionist's departure the hospital open heart surgery program was discontinued for more than twelve months.

j. Roman Catholic Diocese of Albany v. New York State Dept. of Health 490 N.Y.S.2d 636 (App.Div. 1985)

Religious organizations and individual health care consumers brought an action seeking judicial review of a state agency decision granting a CON to a birth control clinic to add abortion services. In the course of holding that petitioners NHPRDA granted had the right to seek judicial review of the state agency's determination, the Court rejected the birth control clinic's argument that NHPRDA was inapplicable to its application because project costs did not exceed the federal capital expenditure or annual operating cost thresholds, holding that: (1) NHPRDA covers capital expenditures in any amount which "substantially change the services" of a facility and the correlative NHPRDA regulation covers capital expenditures irrespective of cost which are associated with a health service addition [citing 42 C.F.R. $123.404(a)(3) (1981) (amended 1985)]; and (2) it cannot seriously be contended that adding outpatient abortion services is not such a new health service.

4. Obligation of a Capital Expenditure

a. State ex rel. Metzler v. Sisters of Charity of Leavenworth 605 P.2d 100 (Kan. 1980)

The State of Kansas brought an action to enjoin a hospital from implementing a cardiac surgery unit without obtaining a CON. The state statute covered substantial changes in services, such as the addition of a cardiac surgery unit, only if their cost exceeded a capital expenditure threshold. The cost of the proposed cardiac unit did not. The federal statute and regulations required complying state CON programs to cover substantial changes in services regardless of cost. The state argued that the Court should interpret the state law to cover the project since the intent of the state legislature was to adopt a statute conforming to federal requirements. The Court declined to look to the federal Health Planning Act and regulations to interpret the state CON statute because the state law was clear and unambiguous.

b. Adam v. Dept. of Public Health 443 N.E.2d 414 (Mass. App. 1982)

A ten-taxpayer group brought two actions, consolidated by the courts, challenging the issuance of a license to a "reproductive healthcare clinic." They claimed that the establishment of the clinic was a CON-covered "substantial capital expenditure" (defined as the "expenditure of a sum of money, including an expenditure for the lease of capital equipment at the purchase value of such equipment, for construction of a healthcare facility which exceeds...[$150K].") consisting of an expenditure of $110K by the clinic and over $40K additional expenditure by the landlord in renovating the premises which the clinic was to occupy by lease. Plaintiffs sought review before the Health Facilities Appeals Board (the state CON administrative appeals body) and judicial review under a statute granting them standing to bring actions to enforce the CON statute. The Court held that the HFAB and the courts lacked jurisdiction because the clinic establishment involved a capital expenditure less than $150K, since the statutory definition did not require the inclusion of the expense of renovations made by the landlord to leased premises.

c. *Cf. District of Columbia v. Washington Hospital Center Health System and Center Properties, Inc.*, C.A. No. 6970-83 (D.C.Super.Ct. *prelim. inj. issued* July 25, 1983; *settlement entered* Oct. 5, 1983)

The SHPDA brought an action seeking to enjoin Washington Hospital Center Health System (WHCHS), a multi-corporate holding company, and Center Properties, Inc. (CPI), a WHCHS subsidiary, from constructing an 800-car parking garage on land (owned by WHCHS and leased to CPI) located on the "campus" or complex of Washington Hospital Center Corporation (WHCC), a second WHCHS subsidiary which operated Washington Hospital Center, a 911-bed acute care teaching hospital. Construction had commenced on the parking garage without a certificate of need being obtained for the project. The project was wholly financed by a bank loan of $4.5 million to CPI secured by a deed of trust and a promissory note executed by CPI in favor of the bank and guaranteed by WHCHS. A sign on the construction site identified the project as a new parking garage for the convenience of Washington Hospital Center patients, visitors, and personnel. The D.C. CON law provided that all persons proposing to obligate a capital expenditure (defined as an expenditure made by or on behalf of a health care facility which is, under generally accepted accounting principles, not properly chargeable as an expense of operation and maintenance) in excess of $600,000 shall obtain a CON prior to the obligation.

The Court granted the District's motion for a preliminary injunction, adopting conclusions of law that: (1) WHCHS was a health care facility for CON purposes; (2) for purposes of the CON Act the capital expenditure for the parking garage project was a capital expenditure on behalf of health care facilities; and (3) the guarantee of the $4.5 million promissory note by WHCHS constituted an obligation of a capital expenditure by or on behalf of a health care facility.

Following this decision and the filing of an appeal by the defendants, the parties entered into a settlement agreement. Under the terms of the agreement WHCHS agreed to apply for a CON on behalf of WHCC to construct a parking facility on the Washington Hospital Center campus.

d. Eagle Hill Corp. v. Commission on Hospitals and Health Care 477 A.2d 660 (Conn. App. 1984)

An alcoholism treatment hospital brought an action seeking judicial review of a Commission decision denying in part its April 1980 request for CON approval of a $705K cost overrun on its previously approved construction project. In 1976 the Commission had approved a $2.7 million capital expenditure to construct the facility. In January, 1979 it approved a $1.6 million overrun. From then till April, 1980 the hospital spent or committed itself to spend an additional $540K for various construction changes, and committed itself to an additional $165K capital expenditure to complete construction and additional financing costs, for a total of $705K. The Commission found that the hospital had inefficiently managed and monitored project costs and neglected to pursue its legal remedies against defaulting contractors or scale back project scope to hold costs to the previously-approved level. Consequently, it denied the $540K portion of the request. It approved the $165K portion with four conditions: (1) hospital submission of its annual operating and capital budgets upon the earlier of attainment of ninety percent occupancy or the end of the first year of operation; (2) annual submission of proposed budgets for six years; (3) hospital reporting of any estimated additional capital costs within one business day; and (4) a prohibition on additional changes in facility scope, cost, or services without the Commission's prior approval.

The state CON law provided in pertinent part: "Any health care facility...proposing a capital expenditure of one hundred thousand dollars or more...shall submit a request for approval of such expenditure...ninety days in advance of the proposed initiation date of such project." (Conn. Gen. Stats. §19-73m (Rev. to 1979)).

The Court held that cost overruns exceeding $100K were subject to review under this provision because a contrary result would exempt major project changes from scrutiny and be inconsistent with the Commission's legislatively-assigned power over major capital expenditures in order to control spiraling health care costs. The Court rejected the hospital's argument that separate CON applications and hearings for construction project change orders would be burdensome, noting that the hospital had several informal and formal avenues for expeditious review of cost overruns. It distinguished Lahey Clinic Foundation, which upheld a SHPDA approval without CON review of cost increases exceeding coverage thresholds caused by inflation and more precise cost estimates, on the grounds that the instant case involved initial approval of actual costs, not estimates, and changes in construction scope, not merely inflation and refined estimates. The Court also held that the Commission's decision did not constitute the promulgation of a regulation in violation of the state APA because: (1) the Commission did not announce a rule of general applicability; and (2) the fact that the Commission's decision had precedential significance did not transform it into a regulation.

Finally, the Court upheld the first two conditions on the $165K approval because: (1) rooted in the Commission's statutory authority to "approve, modify, or deny" a CON application is the power to impose reasonable conditions; and (2) since the Commission had the statutory authority to annually demand submission of annual proposed operating and capital budgets upon 180 days notice, it was within its administrative power to require such submissions in advance with more than the required notice. The Court struck down the second two conditions because they lacked statutory or administrative justification and appeared to stretch administrative oversight into punishment.

e. State ex rel. Pilot Development Northwest, Inc. v. State Health Planning and Development Bureau 701 P.2d 390 (N.M. App. 1985), infra p. 91.

5. Agency Authority to Split Project Into Component Parts

a. Los Alamitos General Hospital v. Lackner 86 Cal. App. 3d 417, 149 Cal.Rptr. 98 (1978)

A hospital brought an action seeking judicial review of the decisions of the SHPDA in the course of CON review severing a portion of the hospital's radiology department remodeling and expansion project from the rest of the project. The state agency approved the non-severed portion under a grandfather exemption, found the severed portion not subject to the grandfather exemption, and denied it a CON. The Court struck down the agency action, holding that the state agency lacked the authority to split the project into component parts unless it expressly found that the so-called components were in fact separately conceived projects.

6. Mergers, Acquisitions, Closures

a. Fraidstern v. Axelrod No. 7414/81 (N.Y.Sup.Ct. New York County, July 16, 1981)

A coalition of elected officials, community leaders, and area residents brought an action against state officials and several hospitals seeking to halt, or compel CON review of, the closure of one hospital and certain corporate changes relating to another. The Missionary Sisters, a religious order, sponsored and comprised the membership of a non-profit corporation which operated Cabrini Hospital. The Franciscan Sisters, another religious order, sponsored and comprised the membership of a non-profit corporation (the "St. Clare's Corporation") which operated two hospitals, St. Clare's and St. Elizabeth's. The Franciscan Sisters amended the Articles of Incorporation of the St. Clare's corporation to change the composition of its membership from themselves to the Missionary Sisters. Steps were also taken to close St. Elizabeth's Hospital and to enter into shared services agreements between Cabrini and St. Clare's. The Court observed that: (1) the transfer of sponsorship of St. Clare's from the Franciscan to the Missionary Sisters was not subject to review under the state CON statute covering "establishment or incorporation" of hospitals because: (a) changes in the person or partnership operating a facility or changes in major shareholders are covered by the statute but sponsoring religious orders are none of those; and (b) the state agency concluded that the change in sponsorship was not covered and agency interpretations of the statute under which they operate are entitled to great weight; (2) the closure of St. Elizabeth's was not subject to review under the state CON statute as a "construction" project because, although the regulations defining construction projects did indicate that changes in bed capacity and physical plant and deletion of discrete services are covered, if the regulatory agency had intended to cover closures it would have made its intentions plainer, and the express listing of covered projects implies the exclusion of all others; and (3) the fact that St. Clare's and Cabrini were embarking on shared services did not mean they had in fact merged, because they continued to be operated as distinct corporations, they had only one common director, and their hospitals were separately licensed.

7. Change in Bed Capacity or Category

a. Mercy Health Center v. Iowa State Department of Health 356 N.W.2d 200 (Iowa 1984)

A hospital brought an action seeking judicial review of a state agency determination that its bed category conversion project was in violation of the state CON law. Mercy had converted acute care beds to SNF beds in a particular hospital unit and had publicly announced that the conversion would not be effective for more than one year. A short time before, the hospital had applied for, been denied, and judicially appealed the denial of a CON application to permanently convert the beds from acute care to SNF. The state CON statute provided for coverage of:

> [A] permanent change in bed capacity, as determined by the department, of an institutional health facility or a health maintenance organization. For purposes of this paragraph, a change is permanent if it is intended to be effective for one year or more.

The Court upheld the state agency determination, holding that the bed conversion violated the CON law because the temporary conversion was in fact a step in the hospital's larger effort to obtain a CON and thus contrary to the state CON statutory provision barring a change in health services prior to receipt of a CON. The Court noted that if a CON applicant who met defeat in administrative proceedings could seek judicial review and simultaneously offer the service for up to one year during the pendency of judicial review, and if the denial were judicially affirmed, the applicant would have been permitted to provide the duplication of services the CON law was intended to prevent.

b. In re Change of Bed Category of Tieszen Memorial Home, Inc. 343 N.W.2d 97 (S.D. 1984)

A personal care facility brought an action seeking judicial review of a state Health Department decision denying it a license to convert five of its "supervised personal care" beds to "intermediate personal care" beds. The Health Department denied the license application on the grounds that a CON was required for the conversion and the SHPDA had recently denied a CON application for the project.

The conversion would not require a capital expenditure. At the time of the facility's license conversion request, the state CON statute covered:

> A bed increase in licensed capacity or permanent change in bed categories, or a decrease in licensed capacity by ten beds or ten percent whichever is less, in any two-year period and which results in a capital expenditure.

The Health Department interpreted this ambiguous statutory provision to require a CON for any permanent change in bed categories regardless of capital cost, reasoning that if the legislature had intended to cover bed category changes only if they resulted in a capital expenditure it would have inserted a comma after "licensed capacity" and deleted the following "or" or deleted the comma after "changes in bed categories."

The Court reversed the Health Department decision, holding that the conversion did not require a CON because: (1) a statutory construction based on punctuation but not conforming to the spirit and purpose of the statute should not be followed; (2) the declared intent of the CON statute was to protect the public from unnecessary health care facility costs; and (3) a change in bed categories requiring no capital expenditure would do no violence to this purpose.

A statutory amendment during the pendency of the appeal of this case provided for coverage of bed category changes regardless of capital cost (but exempted conversions of five beds or less) and coverage of bed capacity decreases in excess of ten beds or ten percent, etc., resulting in a capital expenditure. The Court declined to construe the prior statute in light of this amendment, noting that the amendment might reflect revised legislative objectives.

c. State ex rel. Pilot Development Northwest, Inc. v. State Health Planning and Development Bureau 701 P.2d 390 (N.M. App. 1985), infra p. 91.

C. WITHDRAWAL, EXTENSION, MODIFICATION, AND SUBSEQUENT REVIEW OF CON

1. Extension/Change In Scope/Overrun

a. Lahey Clinic Foundation v. Health Facilities Appeals Board 380 N.E. 2d 675 (Mass. 1978)

A taxpayer group brought an action seeking a declaratory judgment that changes in the scope of a previously approved multimillion dollar hospital construction project were so significant as to require a new CON. The Court refused to grant the relief sought, holding that the state did not improperly exercise its discretion in extending the scope of the CON for the project by approving cost overruns, changes in services, and increases in square footage, (notwithstanding the fact that the overruns and changes in themselves exceeded the CON coverage minimums) because the increases resulted mainly from inflation, more precise cost estimates, and relatively minor refinements in the scope of the project.

b. Alexian Brothers Hospital v. Finley No. A-1179-78 (N.J. Super. Ct. App. Div. 1979)

A competitor brought an action appealing the decision of the state agency approving the modification of a previously approved CON for a 32-bed renal dialysis facility by splitting it into two separately located facilities, one two miles away from the originally approved site. The Court upheld the state agency, holding that the state agency did not exceed its authority in agreeing to modify because the state CON regulations provided a mechanism for administrative review of modification requests and the requested change came soon after the original CON was approved.

c. Pratt v. Board of County Commissioners 597 P.2d 664 (Kan. 1979)

A group of taxpayers brought an action in 1978 to enjoin the issuance of bonds to finance the construction of a new hospital. By law such issuance was conditioned upon possession of a valid CON. In 1976 the new hospital project had been approved and granted a CON by the CHP 314(b) agency and the county had initiated the process of issuance of general obligation bonds to finance the project. However, the issuance was halted (for reasons not relevant here) by the courts. The law under which the 1976 CON was granted provided for a one-year extension for good cause. The state agency extended the CON beyond that period by tolling the running of the clock during the pendency of the litigation involving the financing of the project. The Court reversed, concluding that in the absence of statutory authorization neither the courts nor the state agency had the power to extend the life of the CON pending the determination of the litigation. Compare Lakeside Mercy Hospital, infra.

d. In re Fort Washington Health Care Center Law No. 91,091 (Md.Cir.Ct. Prince George's County Nov. 19, 1982)

A hospital brought an action seeking judicial review of a state CON administrative appeal agency's dismissal of its attempted appeal of the State agency's decision granting its competitor, an ambulatory care center, a CON modification. State agency regulations providing for project modification review authorized the SHPDA to approve/disapprove the modification or to find the modification to be of sufficient scope to warrant full CON review. The state CON statute and regulations granted an aggrieved party the right to appeal a "decision" of the state agency (Md.Ann. Code Art. 41 §59L (1981 Cum. Supp.); COMAR 10.24.01.17 (1980)) but the CON modification regulations also provided that modification approval/disapproval determinations did not constitute judicially appealable state agency "decisions" (COMAR 10.24.01.14 (1980)). The State approved the ambulatory care center modification request, allowing for a 50% cost increase, 10% sq. footage reduction, change in type of financing, and extension of the construction commencement date, finding these changes insufficient in scope to require full CON review.

The Court upheld the state agency decision, holding that the ambulatory care center's modifications were not of sufficient scope to warrant complete review because only if a proposed change goes to the very nature of the project itself is it of sufficient scope to warrant full-blown review. It reasoned that in this day and age of spiraling inflation and sky-rocketing interest rates it is foreseeable that projects undergo some changes in timing or financing during the necessarily lengthy period between certification and first use, and the changes in type of financing and costs of this project did not involve major alterations in the nature of the health services to be offered or in any of the essential elements of the project as it was described and approved in the CON application and review process.

e. *Eagle Hill Corp. v. Commission on Hospitals and Health Care* 477 A.2d 660 (Conn.App. 1984), *supra* p. 85.

f. *State ex rel. Pilot Development Northwest, Inc. v. State Health Planning and Development Bureau* 701 P.2d 390 (N.M. App. 1985)

A nursing home (Pilot) brought an action in mandamus seeking a court order declaring void the DPA's decision recommending approval of its competitor Americare's bed construction project pursuant to a settlement negotiated during an administrative appeal between the DPA and Americare. Pilot had applied for approval of 90 ICF beds. Americare applied initially for 84 ICF/36 SNF. The SHP showed a need for 90 ICF. The applications were batched. The DPA decision approved Pilot's application and denied Americare. By this time the SHP need had grown to 162 ICF. Americare was granted an administrative appellate fair hearing on its denial and Pilot's approval. While the hearing was pending, Americare negotiated a settlement with the DPA under which its administrative appeal was dismissed and the DPA agreed to approve its application as amended to 72 ICF/24 SNF/24 personal care beds not subject to 1122 review. Pilot responded with its mandamus action. The trial court issued a writ of mandamus declaring the settlement void, invalidating Americare's amendment of its application during appeal, and ordering the amended application reviewed anew.

The Court affirmed the trial court's issuance of the writ holding that: (1) the DPA had the implied power under Section 1122 law and regulations to settle the administrative appeal, as long as the terms of the settlement were consistent with 1122 law and regulations; (2) Section 1122 regulations (42 C.F.R. §100.103(a)(2)(v)) require full review of a change in a proposed capital expenditure which is itself a reviewable transaction and the reduction of 12 SNF and 12 ICF beds in the amended Americare application was a reviewable capital expenditure resulting in a decrease in licensed capacity. The Court rejected Americare's contention that bed capacity was unchanged because the initial application and the post-settlement application proposed 120 beds, noting that the distribution of beds among bed categories had changed and that the 24 personal care beds of the settlement were not subject to approval and thus were not to be counted in bed capacity requiring approval. The Court also rejected as absurd and inconsistent with statutory intent Americare's assertion 1122 coverage extended only to proposed capital expenditures in connection with existing facilities, not proposed facilities -- exempting its project. (3) The full review procedures were not followed. The Court observed that the effect of the approval of the Americare proposal by settlement was that 72 beds were awarded to Americare without notice to interested parties, without local HSA review, and without an opportunity for Pilot or others to compete for such beds.

D. EXEMPTIONS FROM CON/1122

1. Statutory Grandfather Clauses

a. Monk and Excelsior, Inc. v. Minnesota State Board of Health 225 N.W. 2d 821 (Minn. 1975)

The builders of a nursing home brought an action seeking a declaratory judgment that the construction of the nursing home was exempt from the CON statute. The Court ruled for plaintiffs, holding that the statutory grandfather clause exempting projects commenced prior to the effective date of the CON statute exempted the project because extensive architectual work and actual on-site construction had begun before the effective date.

b. Palmetto General Hospital v. State Dept. of Health and Rehabilitative Services 333 So.2d 531 (Fla.Dist.Ct. App. 1976)

A hospital brought an action seeking judicial review of a DPA decision refusing to exempt from Section 1122 review its project to complete the shelled-in top floors of its partially constructed hospital. A grandfather clause in the state CON statute (also applicable to Section 1122 review in the state) exempted projects for which land was acquired and construction plans filed before the effective date of the statute. The Court concluded that the grandfather clause exempted the construction project to complete the shelled-in top floors of the hospital, which had been partially completed prior to the effective date.

c. Ross General Hospital Inc. v. Lackner 83 Cal. App. 3d 346, 147 Cal. Rptr. 80 (1978)

A hospital brought an action seeking judicial review of a state agency denial of its application for an exemption from CON of its project to establish a new basic emergency service. The Court reversed the state agency denial, holding that the statutory grandfather clause exempting projects commenced prior to effective date of the CON statute exempted the project because the hospital had entered into binding written contracts for acquisition of the bulk of the physical property which constituted the project before the effective date, notwithstanding the fact that the hospital did not contract to staff the service until after the effective date.

d. Cf. Los Alamitos General Hospital v. Lackner 86 Cal. App. 3d 417, 149 Cal.Rptr. 98 (1978)

A hospital brought an action seeking judicial review of the decisions of the state agency severing the CT scanner acquisition component of its radiology department remodeling project from the rest of the application for the project, approving the non-severed components under a grandfather exemption, denying the severed component a grandfather exemption, and also denying it a CON. The Court held that the state agency lacked the authority to split the project into component parts unless it expressly found that the so-called components were in fact separately conceived projects.

e. Health Resources Foundation v. Dept. of Health 377 N.E.2d 1056 (Ill. App. 1978)

A hospital brought an action seeking judicial review of the decision of the Department of Health denying it a license to establish a new hospital and a declaratory judgment that the state CON statute did not apply to it. Plaintiff's application for a license for the new facility had been pending for several months before and after the effective date of the CON statute. A grandfather clause exempted from CON only those projects for which final construction plans were approved (the last step required to obtain a hospital license) before the effective date. The trial court ordered a license issued (for reasons unrelated to this discussion).

Because it concluded that equity required exempting plaintiff from CON when the delay in issuance of a license was largely the fault of the state, the trial court back-dated its order to a date prior to the effective date of the CON statute, in effect granting plaintiff a non-statutory, equitable exemption from CON. The appellate court reversed, holding that the project did not meet the requirements for a grandfather exemption set forth in the CON law and that the effect of the order exempting the project from review would be directly contrary to the legislative purpose of preventing unnecessary construction.

f. Verdugo Hills Hospital v. State Dept. of Health 88 Cal.App.3d 957, 152 Cal. Rptr. 263 (1979)

A hospital brought an action seeking judicial review of a state agency denial of its application for an exemption from CON of its project to lease-purchase a CT scanner. The Court held that the statutory grandfather clause, exempting projects which, among other things, cannot be terminated without substantial economic loss to the applicant, exempted the lease-purchase of a CT scanner termination of which would cost the hospital approximately $16.5k. Loss of that sum, equal to 13% of the hospital's annual net operating profit, would be substantial.

g. Marin Hospital District v. State Dept. of Health 92 Cal.App.3d 442, 154 Cal. Rptr. 838 (1979)

A district hospital brought an action seeking judicial review of a state agency denial of its application for an exemption from CON of its project to acquire a CT scanner. The Court held that the statutory grandfather clause (exempting projects for which, among other things, a financial obligation was committed or incurred through an enforceable contract or a formal internal commitment of funds to a force account expenditure prior to the CON statute's effective date) exempted a district hospital CT scanner project the funds for which had been levied in taxes and dedicated to the project, giving taxpayers the right to restrain the district from spending the money for other purposes.

h. Wausau Hospitals, Inc. v. Dept. of Health and Social Services 291 N.W.2d 602 (Wis.App. 1980), supra p. 78.

i. Blanchester Care Center, Inc. v. Ackerman No. 81AP-113 (Ohio Ct.App. Franklin Cty. Nov. 5, 1981)

BCC nursing home brought an action seeking a writ of mandamus to compel the state agency to require a competitor, Blanchester Area Care (BAC), to obtain a certificate of need. Prior to June 8, 1979 BAC had obtained approval for its project under the state's 1122 program. In early 1979 the state passed a CON law. Transition provisions in the regulations implementing the statute exempted projects which had received 1122 approval before June 8, 1979 and whose proponents supplied "proof of obligation" for the project. Proof of obligation was defined to required a written enforceable construction contract providing for construction to begin within 90 days of its execution on an already acquired site and to proceed without interruption to completion unless halted by reasons beyond the control of the holder of the CON. (O.A.C. §3701-80-5, 8-01(W)(1979)). Proof of obligation was required to be submitted within one year, with an opportunity for a one-year extension for good cause. BAC obtained a binding option to purchase the land for its proposed facility, conditioned upon rezoning. In part because of delay in obtaining rezoning (including delay caused by an ultimately invalidated petition for a public referendum on the rezoning requested by associates of the BCC) BAC did not enter into a construction contract until May, 1980. In June 1980 the state agency informed BAC that by virtue of its contract it was exempt from CON review provided continuous, uninterrupted construction began within 90 days. Site preparation and bulldozing a portion of the construction site began in late August 1980, but stopped shortly thereafter because of the onset of winter, and the February 1981 filing of this action. In addition, BAC did not acquire title to the property until December 1980, after construction work had begun. BCC argued that BAC was not entitled to an exemption because it did not have an already acquired site when it entered into the construction contract and because uninterrupted construction did not occur within 90 days of the contract's execution.

The Court refused to grant the order sought, holding that the state agency did not abuse its discretion in granting and refusing to revoke BAC's exemption since: (1) the agency had considerable discretion in determining whether or not CON obligation requirements had been satisfied, whether a binding option to purchase constituted an already-acquired site, whether the site work and other construction activity performed by BAC constituted uninterrupted construction, and whether the actions of a competitor to delay implementation of a project constituted reasons beyond the CON holder's control; and (2) regardless of when title to the construction site was actually acquired, the intent of the regulation was satisfied if construction was commenced within 90 days, assuming that delay in obtaining title did not result in any abnormal delay in construction.

j. Cf. Village of Herkimer v. Axelrod 451 N.Y.S.2d 303 (Ct.App. 1983), aff'd on other grounds, 462 N.Y.S.2d 633 (App. Div. 1982)

A municipality which operated a local public hospital brought an action seeking to enjoin as unconstitutional state proceedings under N.Y. PUBLIC HEALTH CODE §2806(6)(a) to modify the hospital's operating certificate to convert it from an acute care hospital to a long-term care facility. The lower court held that the provision in the act enacting §2806 which provided that the act should not be construed to impair any rights incurred prior to its enactment (McKinneys 1976 Sess. Laws of New York Ch. 76, §18 not codified) did not preclude the application of the act to the plaintiff hospital merely because it was in existence before enactment.

k. Cf. Westchester General Hospital v. Dept. of Health and Rehabilitative Services 419 So.2d 705 (Fla. Dist.Ct.App. 1982), infra p. 143.

l. Sisters of Providence in Washington, Inc. v. Dept. of Health and Social Services 648 P.2d 970 (Alaska 1982, modified Sept. 30, 1982)

A hospital brought an action seeking judicial review of a state agency decision that the grandfather exemption of its crosstown competitor's project to construct a new facility had not expired because the project had been substantially implemented. Construction on the project had been stalled at the initial ground preparation and foundation stage due mainly to financing problems. The statutory grandfather clause provided that projects under construction before a specified date were entitled to a CON. State regulations provided that the CON would expire after a specified period of time if the project were not "substantially implemented", and set forth general criteria for substantial implementation (Alaska Admin. Code §07.090(d),(e),(f)). The regulations did not set forth specific procedures for making the decision that a project had been substantially implemented, nor did the CON statute or regulations provide for judicial review of such decisions, but they did permit substantially or directly affected parties to appeal CON decisions and to bring enforcement and CON revocation actions.

At the competitor's request and following notice and receipt of comments by interested parties, such as the plaintiff, the state agency issued a decision that the project had been substantially implemented. The hospital then brought this action.

The Court held that: the state agency's substantive criteria for "substantial implementation" were not invalid on the grounds that they set too low a standard, permitting a finding of implementation based on token activity. The criteria permitted a finding of implementation based on any one of the following: completion of proposed activity of any kind; equipment installation; operating license modification; signing of a construction contract; expenditure of twenty percent of project cost; or any similar expenditure or obligation. However, the Court remanded to the trial court for determination whether there was substantial evidence to support the agency's decision that the project was substantially implemented.

m. Schatzman v. Dept. of Health and Rehabilitative Services ("In re King Memorial Hospital II") 19 B.R. 885 (U.S. Bankruptcy Ct. S.D. Fla. 1982)

A trustee in bankruptcy brought an action seeking an order declaring it the possessor of a CON exemption for a project to construct a 126-bed facility. The factual background of this case is described in the annotation to Schatzman v. Dept. of Health and Rehabilitative Services ("In re King Memorial Hospital I"), supra p. 41.

The Court held that it had jurisdiction over the subject matter of the proceeding and that, the debtor having filed a petition under Ch. XI, the case was subject to the U.S. Bankruptcy Code. Concluding that DHRS properly set forth the requirements for preserving a CON exemption, e.g. that the project be under physical and continuous construction pursuant to DHRS-approved final construction plans by July 1, 1979, the Court first held that the King project met the requirements because: (1) King met the "physical and continuous construction prior to July 1, 1979" requirement based on the facts that it had hired an architect and engineer, the construction site was levelled and prepared, a survey was taken, and a permit for foundation work was obtained by the building contractor prior to that date; and (2) the June 25, 1979 DHRS approval for commencement of foundation work was sufficient grounds for King to meet the requirement of "construction pursuant to final construction plans."

Second, the Court held that: (1) it was not unreasonable for DHRS to require that the project maintain continuous construction activity after July 1, 1979 to continue to preserve its CON exemption, since otherwise a project could appear to commence construction prior to July 1, 1979 and then not in good faith go forward with actual construction, thereby frustrating the intent of the legislature to repeal the grandfather exemption; and (2) King met the "continuous construction" requirement because: (a) continuous construction through July 31 was evinced by DHRS approval of schematic plans on that date; (b) the requirement was then met through August 15 by King pursuing financing arrangements for the project; and (c) from August 15 to October 2, 1979 the requirement was met by the fact that although DHRS had the opportunity to do so, it did not commence an administrative complaint during this time. Then, the filing by King of a Petition in Bankruptcy on October 2, 1979 effectively prevented continuation of construction and stayed any further proceedings the purpose of which would be forfeiture of the CON exemption. (See "In re King Memorial Hospital I", supra.

2. Exemption for Facility Replacement/Remodeling

a. Bakersfield Community Hospital v. Dept. of Health 77 Cal.App. 3d 193, 142 Cal.Rptr. 773 (1977)

A hospital proposing to construct a new facility on a site three miles from its existing facility petitioned the Court to order the SHPDA to determine that the proposed site was adjacent to the existing facility. Under state law projects to relocate hospital facilities in sites "immediately adjacent" to existing facilities' locations were exempt from CON. The Court concluded that the proposed site was not "adjacent," reasoning that the state legislature intended that words in statutory CON exemptions be narrowly construed to the end that exemptions not be unduly expanded.

b. Placentia-Linda Community Hospital, Inc. v. Zaretsky 107 Cal.App.3d 850, 166 Cal.Rptr. 7 (1980)

A hospital brought an action appealing the denial of its request for a "remodeling and replacement" CON exemption for its project to add a new 3,300 sq. ft. wing relocating existing beds from three-bed rooms to two-bed rooms in the new space and retaining the existing space for other uses. The state statute exempted proposals for the remodeling of existing health care facilities or the construction of any new health care facility to replace in whole or in part any existing facility. The state agency denied the application on the grounds that the project constituted an "expansion" of the facility, and expansion was not included within the meaning of "remodeling" or "construction to replace" because: (1) another provision of the state statute defined the word "modernization" to include each of the three words "expansion," "remodeling," and "replacement" implying that each of the words had an exclusive meaning; and (2) a contrary interpretation would open the floodgates for expansion of hospital facilities under the guise that the expansion was only incidental to remodeling or replacement. The Court held that the project was entitled to an exemption because: (1) construing the language of the exemption provision to include the concept of addition or expansion is consistent with the policy of the state statute to allow health care facilities to make relatively small capital expenditures without undergoing review; and (2) the state agency interpretation was absurd because in order for new construction to qualify for exemption under the state interpretation it would be necessary to abandon an equivalent amount of space, which would be diametrically opposed to the purpose of the act by requiring economic waste.

3. Exemption for Projects Required by Law or Regulation

a. Community Hospital of Los Gatos and Saratoga v. Office of Statewide Health Planning and Development 3 Civ. 19970 (Ca.Ct.App. 3rd Dist. Aug. 27, 1981)

A hospital brought an action seeking judicial review of a SHPDA decision denying its application for a certificate of exemption from CON for its project to reconstruct its emergency room. The state CON statute exempted projects undertaken, "solely for the purpose of complying with requirements of law or regulations" and state regulations specified that the "requirements of law or regulations" meant those with which the facility was under a legal duty to comply. State hospital licensing officials had inspected the facility, identified certain deficiencies which were not health and safety hazards, and stated in communications with the hospital that the state would require the hospital to institute corrective alterations or construction. However, the hospital was not actually under a legal duty to correct the deficiencies because: (1) the hospital was exempt from compliance under a grandfather clause in the licensure regulations; and (2) the licensure agency's practice was not to require correction unless the deficiencies were a hazard to health and safety. The SHPDA denied the application on the grounds that the project was not actually required by law or regulation. The Court held that the hospital was entitled to a certificate of exemption because it was led to believe by the hospital licensing agency, did believe, and acted on the belief that it was required by regulation and law to undertake alterations.

4. Special Legislative Exemptions

a. Commissioner of Public Health v. Bessie M. Burke Memorial Hospital 323 N.E.2d 309 (Mass. 1975)

A state agency brought an action for a declaratory judgment as to the constitutionality, under the Fourteenth Amendment and provisions of the state constitution prohibiting special legislation and violation of the doctrine of separation of powers, of a statute commanding it to issue CONs to certain projects it had previously disapproved. The Court upheld the statute concluding that such statutes are invalid only where they do specific injury to identifiable persons, not where, as here, they may merely increase costs to the public over the long run.

b. Paul Kimball Hospital v. Brick Township Hospital, Inc. 432 A.2d 36 (N.J. 1981)

A hospital brought an action challenging the constitutionality under the Equal Protection Clause of the Fourteenth Amendment and the prohibition on special legislation in the state constitution of a state statute exempting from CON hospital construction projects for which land located within a municipality had been acquired and municipal funds appropriated prior to the effective date of the CON statute. The statute had the effect of exempting one proposed facility, plaintiff's competitor, from CON. The Court held that: (1) the statute did not violate equal protection because it was reasonable for the legislature to single out the hospital classified by the statute as entitled to a grandfather exemption since: (a) a governmental entity (the municipality) had judged them necessary; and (b) the proponents of the proposed hospital had acquired the land in good faith reliance on the state of the law prior to the CON statute; and (2) the statute was not impermissible special legislation because it was based on a classification rationally justified by the municipal government's identification of need and the proponent's acquisition of land in reliance on prior law.

c. Rush City Hospital v. Sandstone Area Hospital and Nursing Home, Inc. No. 82-398 (Minn. Sup. Ct. Nov. 24, 1982)

A competitor hospital brought an action seeking a declaratory judgment that a state statute exempting from CON a specific project planned by another hospital was unconstitutional as special legislation. In 1977 a county Board of Commissioners sold its hospital to a private non-profit corporation. As part of the sales agreement the Board endorsed a facility plan for acute and long-term care in the county which called for the designation as acute care beds of ten long-term care beds at a for-profit nursing home owned by the individual who submitted the nonprofit corporation's bid to the Board. In 1981 the state legislature passed special legislation permitting the non-profit corporation to fulfill its contract with the Board without complying with the state CON statute. The state constitution prohibited special legislation but excepted special laws which related to a single local government unit, provided that such laws not become effective until approved by the voters or the governing body of the affected unit. The Court held that the special CON exemption legislation fell within the local government unit exception because a local government unit was affected. However, it ruled that the special legislation had not yet become effective because it had not yet been approved by the local unit of government.

5. Non-Statutory Exemptions

a. Zurbrugg Memorial Hospital v. Commissioner of Health No. A-931-74 (N.J. Super. Ct. App. Div. Nov. 13, 1975)

A hospital brought an action appealing the decision of the Commissioner of Health granting it a non-statutory, equitable exemption from CON subject to the condition that the exemption was valid only one year and would be forfeitable if the hospital failed to make substantial progress on the project within that time. The Court held that the Commissioner of Health had the authority under the state CON statute (which gave the Commissioner broad discretion to issue CONs to projects which were needed and financially feasible and which contributed to the orderly development of adequate, effective areawide health services) to grant the hospital construction project an exemption from CON requirements on an equitable basis because of substantial expenditures incurred prior to the adoption of the statute. The statute did not expressly provide for exemptions. The Court then held that since the Commissioner had the equitable power to grant an exemption, he had the correlative power to impose conditions which were reasonable under the circumstances. Finally, the Court held that the particular condition imposed was not unreasonable because: (a) without such a limitation the hospital could delay interminably on its project, and (b) the limitation imposed by the condition mirrored the time limitation imposed by state law on all certificates of need.

b. Cf. Health Resources Foundation v. Dept. of Health 377 N.E.2d 1056 (Ill.App. 1978), supra p. 93.

c. Roskey v. Texas Health Facilities Commission 630 S.W.2d 844 (Tex.Civ.App. 1982)

A taxpayer's association brought an action seeking a declaratory judgement that a CON exemption certificate issued to a district hospital was invalid. The application for the exemption certificate was filed on April 25, 1979 and approved on July 26, 1979. Between those dates, on May 17, 1979, a statutory amendment became effective repealing the sole ground on which the exemption certificate was issued.

The Court first concluded that the Commission lacked statutory authority to issue the exemption certificate because: (1) the amending statute contained no saving clause in favor of pending applications and the hospital district had not acquired a vested right immune from the retroactive application of the statute because the Commission had not yet acted when the amending statute became effective; and (2) the amending statute could not be construed not to apply to pending applications through administrative agency "interpretation" or testimony of the sponsoring legislator as to the legislative intent because the statute was unambiguous and required no extrinsic interpretive aid.

However, the Court held that the plaintiffs lacked standing to bring the action. The taxpayers alleged that the district intended to levy new taxes to pay for the project authorized by the exemption certificate. Because the district had not yet taken any steps to levy such taxes and because it had the authority to finance the project through other than tax revenues, the Court ruled that the plaintiff's alleged injury was founded on a contingency, insufficient to support standing. The Court concluded that at this point the exclusive right to contest the validity of the exemption certificate lay with the state through an action in quo warranto against the hospital district.

6. Relationship Between CON and 1122 Exemptions

a. Palmetto General Hospital v. State Dept. of Health and Rehabilitative Services 333 So.2d 531 (Fla.Dist.Ct. App. 1976)

A hospital brought an action seeking judicial review of a DPA decision denying its project to complete a partially constructed hospital an exemption from Section 1122 review. The DPA hearing officer had found that the project was exempt from state CON review under a statutory grandfather clause. The Court held, among other things, that the fact that the project was exempt from CON in no way controlled the determination of the Secretary of HHS on the question of whether or not he would exempt the project from 1122 review.

E. TRANSFERABILITY OF CERTIFICATE OF NEED

1. Texas Health Facilities Commission v. El Paso Medical Surgical Associates 573 S.W. 2d 291 (Tex.Civ.App. 1978)

A medical group which had been granted a CON to establish a day surgery outpatient center brought an action seeking judicial review of the state agency refusal to transfer the CON to a hospital - the center to be relocated in the hospital. State law provided for transfer of a CON prior to completion of the project on good cause as determined by the state agency. The state agency refused to grant the transfer because the proposed facility would be relocated and suggested that the hospital apply for a CON to establish a center. The Court held that the state agency did not err in denying the transfer request, because: (1) the state CON criteria are "facility specific" (i.e., a project must be analyzed for consistency with the criteria in the context of the particular parent facility in which it will be located) and a project relocated in a new facility under the CON transfer procedure would circumvent the facility specific criteria; and (2) the public notice required by law of proceedings to transfer CONs is much shorter than the notice period for a CON application review proceeding, as is the period within which to acquire party opponent status, and therefore allowing a change of location by CON transfer rather than by a new CON application might allow an applicant to utilize the transfer procedure as an avenue to circumvent the full notice requirements and thereby minimize possible opposition.

F. ENFORCEMENT OF CERTIFICATE OF NEED STATUTE

1. People v. Wickersham Women's Medical Center 329 N.Y.S. 2d 627 (N.Y.Sup.Ct. Spec.Term. 1972)

A state Attorney General brought an action to enjoin an abortion clinic from continuing to operate without first obtaining a CON. The clinic filed a CON application after the commencement of the lawsuit and argued that no injunction should issue because no irreparable injury to the public was shown. The Court held that the fact that obtaining a CON requires an application and exhaustive investigation including, where required, public hearings and that approval may be had only where certain standards are met indicates that the legislature intended that the CON approval requirement be a matter of consequence in protecting public health. These circumstances indicated that continued operation without approval might cause public injury, and they outweigh any economic hardship on the defendants that might accompany closing the clinic.

2. Mercy Hospital v. Rate Setting Commission 407 N.E.2d 337 (Mass. 1980)

   A hospital brought an action seeking judicial review of a hospital rate-setting commission order denying it approval for new charges for a CT scanner which, the commission had determined, the hospital had acquired without obtaining the requisite CON. The Court held that the commission had authority to issue such a denial because it had general power to set forth substantive standards for reviewing applications for new charges and common sense indicated that the general power authorized a regulation providing for denial of charges arising through the provision of presumptively illegal services. The Court also ruled that in adopting the regulation the rate-setting commission did not improperly exceed its jurisdiction by behaving as an "enforcement agency" for the CON statute because: (1) the statutes governing rate-setting and CON have the common goal of controlling costs, and (2) occasional incidental denial of approval for charges associated with projects instituted without a CON will not usurp the SHPDA's CON functions.

3. Schatzman v. Dept. of Health and Rehabilitative Services ("In re King Memorial Hospital I") 4 B.R.704, 6 B.C.D. 634, 2 CBC2d. 639, CCH BANKR.L.RPTR ¶67,685 (U.S. Bankruptcy Ct. S.D. Fla. 1980), supra p. 41.

4. Pee Dee Regional Health Systems Agency, Inc. v. Department of Health and Environmental Control No. 79-CP-40-3626 (S.C.Ct.C.P. May 13, 1981)

   An HSA and others brought an action against the Department of Health and others seeking judicial review of a decision approving an application for a CON to construct a unique "long-term care rehabilitation facility" providing both traditional nursing home services and extensive, specialized rehabilitative services. In granting the CON for the facility the state agency indicated that it would assure that the proposed facility would in fact provide unique, needed specialized rehabilitative services and not merely traditional nursing home services (for which no need was shown) by conditioning the facility's license on the performance of such specialized services. The Court concluded that the Board possessed the authority to attach such a condition to a licensure approval, even in the absence of express statutory authorization. (Compare Huron

Valley Hospital, Inc. v. Michigan State Health Facilities Commission, supra.

5. Finger Lakes Health Systems Agency v. St. Joseph's Hospital 412 N.Y.S. 2d 419 (App.Div. 1981)

A state Attorney General brought an action seeking to enjoin a hospital, a professional corporation of radiologists, and others from operating a CT scanner in an addition to the hospital without first obtaining a CON. Before the filing of the lawsuit the hospital had constructed a medical office building adjacent to its facility (and connected to it by an enclosed walkway) and leased space in the building to the radiologists. They installed the scanner in the leased space, contracted with the hospital for technicians to assist in operating the scanner, and provided scanning services to hospital and non-hospital patients. The Court dismissed the action after weighing in the balance the probability of hardship to each of the parties. The Court concluded that on the government side there existed only the possibility of a statutory violation with no demonstrated public harm or detriment. On the defendants' side, if the injunction were granted it would require the razing or converting of the new building specially constructed to house the scanner, loss of the investment of considerable private funds in the purchase of the scanner, cancellation of the contracts and the lease already negotiated, and deprivation of the patient care already undertaken.

6. Shenango Valley Osteopathic Hospital v. Dept. of Health of Pennsylvania 451 A.2d 434 (Pa. 1982)

A hospital brought an action seeking: (1) judicial review of a state agency determination that its acquisition of a CT scanner was subject to CON review; (2) declaratory and injunctive relief relating to the constitutionality of the CON statute; and (3) interim special relief permitting it to operate the scanner while its application for a CON to acquire the equipment underwent review by the state and local health planning agencies. Without obtaining a CON, the hospital had purchased and accepted delivery of the $268K scanner in July and August of 1981, at which time the state CON statute covered capital expenditures in excess of $165K. On October 1, 1981 the statute was amended, increasing the capital expenditure threshold to $600K but continuing coverage of any "addition of a health service" regardless of the value of the capital expenditure associated with the health service addition. The state agency then determined that the acquisition was covered as a health service addition and ordered the hospital not to operate the scanner until it obtained a CON. The hospital appealed the agency's coverage determination to an administrative appeals board (the State Health Facility Hearing Board), filed a CON application, and brought this action, in which among other things it raised constitutional objections to the CON statute on vagueness and unlawful delegation grounds.

The Court ruled that the hospital was not entitled to the interim special relief sought because: (1) although the constitutional issues raised were sufficient to relieve an exhaustion bar, they did not establish a sufficient likelihood of success on the merits to warrant the granting of preliminary relief; (2) the interests of justice did not require granting the relief requested since, although the failure to do so means the scanner will sit idle, these and other intrusions on facility autonomy are necessary incidents of legislatively-adopted comprehensive health planning; and (3) the facts that: (a) whether the hospital may presently operate the scanner without a CON is still at issue; (b) even if it could do so (in which case the only disputed issue would be whether the hospital violated the CON statute before the expenditure threshold increase) the matter of the gravity of its alleged earlier violation; and (c) its initial failure to notify the state agency of the acquisition all argue against equitable intervention.

III. CON AND 1122 APPLICATION REVIEW PROCEDURE

A. ADMINISTRATIVE REVIEW PROCEEDINGS

1. Applicability of State Administrative Procedures Act

a. To State Proceedings

(1) NOTE: In a number of cases SHPDAs have been held to or reviewed under the standards in state APAs without specific, express holdings by the Court that the APA applied in CON review. See, e.g., Oklahoma Pioneer, Inc. v. Carpenter; Cheshire Community Hospital v. Commission on Hospitals and Health Care.

(2) West Virginia Health Systems Agency, Inc. v. State Health Planning and Development Agency No. AP-CA-80-1 (W.Va.Cir.Ct. Kanawha County July 2, 1980)

An HSA brought an action seeking judicial review of the decision of the State Tax Department to issue a CON for construction of a replacement facility. The Tax Department had been designated by the governor as an independent reviewing body to hear administrative appeals of SHPDA decisions on CON applications. The HSA had recommended disapproval of the hospital's application. In reviewing the HSA's allegations the Court held that: (1) the state APA provisions on judicial review of contested cases did not govern the case because the Tax Commissioner was expressly excluded from those provisions of the APA, and (2) nevertheless, the Court would use the APA provisions as a appropriate guide since they were a codification of standards of judicial review formulated by case law prior to the enactment of the APA.

(3) Hale v. Petit 438 A.2d 226 (Me. 1981)

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the concurrent granting of a CON to the other applicant. Under the statutory state CON review process the applicant was entitled to an HSA public hearing but not to an administrative hearing by the state. (The state could grant a reconsideration hearing, but only for good cause). The Court upheld the state agency decision, holding among other things that the HSA public hearing and state agency reconsideration hearing processes were not subject to the state APA provisions governing administrative adjudications because the statutory scheme of the CON law as a whole was so inconsistent with the procedures set forth in the state APA as to indicate a legislative intent that the APA not apply.

(4) In re HCA Health Services of Wyoming, Inc. 689 P.2d 108 (Wyo. 1984)

A competitor brought an action seeking judicial review of a SHPDA decision granting a CON to its competitor for facility replacement and addition of beds. The SHPDA had approved the application following informal public meetings. The state CON statute required the SHPDA to notify affected persons of the commencement of a CON review and to conduct a "public meeting" on each CON application. State CON regulations provided for an informal public meeting without opportunity for sworn testimony, confrontation, or representation by counsel. The state APA provided for formal, "trial-type" hearing procedures in all "contested cases", defined as cases where the law, independent of the APA, required a formal hearing.

The Court held that the SHPDA was required to conduct a formal APA hearing on the CON application at the request of the plaintiff because: (1) States choosing to participate in NHPRDA must abide by the procedural due-process requirements of the Act. The Court cited Park East Corp. v. Califano and Greater St. Louis HSA v. Teasdale for this proposition. (2) NHPRDA and implementing regulations require a SHPDA to conduct a formal hearing at the request of affected persons (42 U.S.C. §300n-1(b)(1), (12)(A); 42 C.F.R. §123.401, 410(a)(8). (3) The "public meeting" requirement of the state CON statute should be read to derive meaning and substance from the NHPRDA formal hearing requirements. The Court indicated that this reading of the "public meeting" requirement would effectuate the purpose of the legislature to adopt a certificate of need review process that complied with federal requirements and qualified the state for financial assistance, and that the overall statutory scheme of CON review including the availability of judicial review supported a reading in which the term "public meeting" incorporated a formal, trial-type hearing. (4) Under the foregoing reading, the term "public meeting" in the CON statute triggered the contested case provisions of the state APA and any affected person as defined by pertinent federal and state CON regulations, including the plaintiff, would be entitled upon request to participate as a party in such contested-case CON proceedings.

b. To HSA Proceedings

(1) American Medical International, Inc. v. State Health Planning Advisory Council No. 165724 (Az.Super.Ct. Pima County February 1, 1979)

A hospital brought an action to, among other things, compel an HSA to deem its application for a CON to construct a hospital complete and to grant it a hearing on the application. In reviewing this claim the Court held that the state APA did not apply to the HSA because the HSA was not a state agency.

2. Applicability of constitutional due process requirements to administrative review proceedings.

a. Due Process Requirements Apply

(1) Merry Heart Nursing and Convalescent Home, Inc. v. Dougherty 330 A.2d 370 (N.J.Super.Ct. App.Div. 1974)

A nursing home brought an action seeking judicial review of a CON appeals board decision remanding its bed expansion CON application to a state agency hearing officer with directions that the need for its project be reviewed for conformity with the State Plan for Health Services as updated shortly after its application was filed. In ruling that the applicant was not denied due process by the use of the post-filing update information, the Court noted that the applicant was clearly entitled to due process of law in the determination of its application for a CON.

(2) Suburban Medical Center v. Olathe Community Hospital, 597 P.2d 654 (Kan. 1979)

A competitor brought an action seeking review of a SHCC decision granting a CON to a community hospital for a project to expand its facilities and add beds. The Court held that the requirements of due process applied to the SHCC proceeding to review the CON application because such a proceeding is a quasi-judicial function.

(3) Hale v. Petit, No. C.V.81-2 (Me.Super.Ct. Kennebec County February 28, 1981), aff'd, 438 A.2d 226 (Me. 1981)

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the granting of the other. The Court upheld the state agency's decision. In reviewing the plaintiff's allegations of procedural irregularity the Court held that certificate of need administrative review involves substantial property interests and the administrator must comply with the prerequisites of due process in carrying out his delegated responsibility to issue certificates of need.

b. Due Process Requirements Do Not Apply

(1) Cf. Thirteen Southfield Associates v. Dept. of Public Health 267 N.W.2d 483 (Mich.Ct.App. 1978)

A nursing home brought an action seeking judicial review and a declaratory judgment that the state department was obligated to hold a hearing on its application for state certification to HUD of need for its construction project. State certification was a prerequisite to receipt of FHA mortgage insurance from HUD. The Court held that state and federal constitutional due process clauses did not mandate a hearing on plaintiff's application because plaintiff did not have a prospective property interest in obtaining certification.

(2) American Medical International, Inc. v. State Health Planning Advisory Council No. 165724 (Az.Super.Ct. Pima County February 1, 1979)

A hospital brought an action to, among other things, compel an HSA to deem its application complete and grant it a hearing on its application for a CON to construct a new hospital. Under the Arizona CON statute applications were considered incomplete unless they contained proof of conformance to the local health systems plan. The HSA had determined that the hospital's application did not. The state CON law did not require the HSA to hold a hearing under those circumstances. The Court held that the hospital's procedural due process rights had not been violated by the local agency's finding of incompleteness because the hospital's expectation that it might be granted a CON was not a property right which would entitle it to due process protections.

3. Requirement of Adoption of Application Review Procedures

a. Cf. cases discussed at pp. 165-67, infra, concerning promulgation of rules governing administrative appeals of Section 1122 decisions.

b. In re Behavioral Science Institute 436 A.2d 1329 (N.H. 1981)

An institute proposing to construct a new psychiatric hospital brought an action appealing the denial of its CON application. The institute had filed its notice of intent on October 25, 1979, and its application on January 25, 1980. From the time of the NOI up until August 6, 1980, when the application was approved by the state agency the scope, location, and cost of the project underwent numerous changes. The HSA and a competitor (who also had an application for a psychiatric hospital pending) requested a reconsideration hearing at which the application was denied. The Court reversed and remanded the application to the state agency for re-review following the adoption of rules and regulations setting forth application review procedures, including definitions of "substantial amendment" of an application, "completeness," and "competing" applicants, because by failing to promulgate such rules the state had created an atmosphere of pervasive confusion surrounding the application, including failure to notify affected parties of fundamental changes in the proposed project.

c. Sisters of Providence in Washington, Inc. v. Dept. of Health and Social Services 648 P.2d 970 (Alaska 1982, modified Sept. 30, 1982)

A hospital brought an action seeking judicial review of a state agency decision that the grandfather exemption of its crosstown competitor's project to construct a new facility had not expired because the project had been substantially implemented. Construction on the project had been stalled at the initial ground preparation and foundation stage due mainly to financing problems. The statutory grandfather clause provided that projects under construction before a specified date were entitled to a CON. State regulations provided that the CON would expire after a specified period of time if the project were not "substantially implemented", and set forth general criteria for substantial implementation (Alaska Admin. Code §07.090(d), (e), (f)). The regulations did not set forth specific procedures for making the decision that a project had been substantially implemented, nor did the CON statute or regulations provide for judicial review of such decisions, but they did permit substantially or directly affected parties to appeal CON decisions and to bring enforcement and CON revocation actions.

At the competitor's request and following notice and receipt of comments by interested parties, such as the plaintiff, the state agency issued a decision that the project had been substantially implemented. The hospital then brought this action. The Court held that the state agency's failure to establish specific procedural guidelines by regulation for making "substantial implementation" decisions did not render its decision void because the agency did provide reasonable informal notice and comment procedures.

d. Cf. Humana Medical Corporation v. Schweiker No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. DHHS had excluded reimbursement for lack of timely notice pursuant to a DHHS Policy on Lack of Timely Notice which had been published in the Federal Register (42 Fed.Reg. 4847 (Jan. 26, 1977)), but not formally adopted as a regulation. The hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc. dealt with elsewhere in the GUIDE. It also argued that the Policy on Timely Notice was invalid because it was not formally adopted in accordance with the federal APA. The Court rejected this argument, holding that DHHS did not violate the federal APA by failing to promulgate the Policy on Lack of Timely Notice as a formal agency rule because the policy was merely an interpretive rule or statement of policy rather than a substantive or legislative rule.

4. Requirement of Notice of Proceedings

a. In re Behavioral Science Institute 436 A.2d 1329 (N.H. 1981)

An institute proposing to construct a new psychiatric hospital brought an action appealing the denial of its CON application. From the time the institute's notice of intent (NOI) to file a CON application was filed until the time the state agency finally denied the application (at a reconsideration hearing requested by the HSA and a competitor who had filed an NOI and an application for a new psychiatric hospital after the institute's application was complete) the institute's application was repeatedly amended to reflect changes in the scope, location, financing, and cost of the project. As required by the state CON statute the state agency published public notices of the receipt of the NOI and the commencement of review of the completed application, and individually notified certain "affected persons" as defined by statute. However, no notice of the various amendments to the application was given. The Court reversed the state agency decision, holding that: (1) both the institute and the competitor were given inadequate notice from the state agency concerning the existence of competing applications; and (2) when there are amendments and changes in an application, all affected parties and the public should be given notice, particularly when the changes are material changes such as the location of the facility, the number of beds, or the capital cost.

b. Nueces County Hospital District v. Texas Health Facilities Commission 576 S.W.2d 908 (Tex.Civ.App. 1979)

A hospital brought an action appealing the granting of a CON to acquire a CT scanner to its competitor and the denial of its application. [The trial court severed the two causes of action. This case concerns the hospital's appeal of the competitor's CON. Texas Health Facilities Commission v. Nueces County Health District 581 S.W.2d 768 (Tex.Civ.App. 1979) concerns the hospital's appeal of the denial of its application - Ed.] The applications, both of which were for a CT scanner in Corpus Christi, had been filed approximately one month apart. The state agency had formally designated them as "potentially competing applications" and considered them in a single hearing. The hospital alleged that the state agency erred in not notifying it that the two applications would be considered "mutually exclusive". The Court held that the hospital had sufficient actual notice that the applications might be mutually exclusive before the hearing because the state agency designated the applicants as potentially competing and the state could not be expected to know whether the applications were truly mutually exclusive until it heard and considered the evidence of community need at the hearing. Therefore, the hospital had ample opportunity to respond to the possibility that the state agency might only grant one application by presenting evidence at the hearing and by arguing that its application should be preferred.

5. Requirement of Completeness of Application

a. 1122 Cases

(1) Nebraska Methodist Hospital v. Casari No. CV77-L-256 (D.Neb.Aug. 18, 1978); [1978 Transfer Binder] Medicare and Medicaid Guide ¶29,205., infra p. 165.

(2) See Canonsburg General Hospital v. Dept. of Health 413 A.2d 1185 (Pa. Cmwlth 1980), rev'd on other grounds 422 A.2d 141 (Pa. 1980)

A hospital brought an action seeking by way of a writ of preemptory mandamus to obtain review of the decision of the DPA refusing to declare complete its application under Section 1122 to construct a new hospital, and seeking a court order that the DPA declare the project "deemed approved." The DPA (acting through the HSA, which performed initial review of 1122 applications) had received the application on April 16, 1979, and on April 30, 1979, had sent the applicant a notification of incompleteness requesting additional information. On May 30, 1979, the applicant supplied some information to the HSA. The HSA notified applicant several times thereafter that it still considered the application incomplete. The HSA informed the applicant that it would not consider the application complete until the applicant took action to explore alternatives to the project with other hospitals.

When a Section 1122 application is incomplete, the federal 1122 regulations (42 CFR §100.106(a)(3),(4)): (1) require the DPA to send a notification of incompleteness within 15 days of receipt of the application, (2) require the DPA to notify applicant of its disapproval of the application 90 days after receipt of the additional information requested in the notification of incompleteness, and (3) provide that failure to provide timely notification of disapproval is deemed an approval (42 CFR §100.106(a)(4)). The trial court had held that the HSA/DPA had only one 15-day period to request additional information, citing Nebraska Methodist Hospital v. Casari, supra and an earlier administrative interpretation of the state's 1122 regulations, and had ordered the project deemed approved. The Supreme Court reversed on another ground, holding that the hospital failed to exhaust its administrative remedies when it brought this action before pursuing an administrative complaint mechanism which was available to it under state law.

b. CON Cases

(1) Olathe Hospital Foundation, Inc. v. Extendicare, Inc. 539 P.2d 1 (Kan. 1975)

Several hospitals brought an action for judicial review of a state agency appeals panel's final decision granting a CON to their competitor to construct a new hospital. The application had been initially submitted to a regional Comprehensive Health Planning agency which had made a series of requests for additional information from the applicant and then, still expressing its dissatisfaction, had formally reviewed the application. The state statute required an application to be complete before it was considered by a planning agency, and authorized the agency to require additional information from an applicant. The plaintiffs alleged that the application had never been completed, rendering the final project approval void. The Court disagreed, holding that by accepting and formally considering the application the regional agency had deemed it complete. The Court observed that on the one hand the agency could not postpone a decision indefinitely by making unwarranted demands for unobtainable data and on the other hand if the agency had a legitimate need for more information it should not have accepted the application.

(2) Cf. Humana Medical Corp. v. State Health Planning and Development Agency 460 So.2d 1295 (Ala.Civ.App. 1984), infra p. 253.

(3) United Hospital Center, Inc. v. Richardson 328 S.E.2d 195 (W.Va. 1985)

A hospital brought an action in mandamus seeking to compel a state agency to process its application for a CON to acquire a MRI unit. After the hospital's application was filed the state agency imposed an administrative moratorium on the acceptance and determination of completeness of CON applications for MRI, relying as authority for the moratorium on a statutory provision commanding it to take actions in the exercise of its CON and other functions to allocate the supply of health services not appropriately allocated by competition. The immediate purpose of the moratorium was to gain sufficient time to develop MRI review criteria. On the basis of the moratorium the state agency declined to determine the completeness of the hospital's application or to further process it. The state CON statute required the state agency to determine whether an application was complete within 15 days of receipt, and generally required 90-day review after determination of completeness. The court granted the hospital's petition and ordered the state agency to determine whether or not the application was complete, holding that: (1) the general authorization to allocate supply did not authorize the state agency to ignore the 15-day completeness determination requirement; and (2) the moratorium imposition was arbitrary and capricious because it was unnecessary since existing statutes and regulations (which permitted the agency to adopt criteria for determining when 90-day review would be impracticable, to adopt varying CON review regulations for different health services, and to use national or commonly-accepted review standards when local or state standards were unavailable) allowed an opportunity for the development of MRI standards during the agency's regular review process.

6. Requirement of a Hearing

a. Bicknell v. Annas No. 74-27 Equity (Mass. Sup.Jud.Ct. Mar. 12, 1974)

The Department of Public Health sought a ruling staying the order of the Health Facilities Appeals Board that the Department hold an adjudicatory hearing on a CON application. The Court declined to stay the order but concluded that: (1) the CON statute did not require a departmental hearing in every instance; and (2) due process requires a hearing only where the Department considers adjudicatory-type issues. Thus, when the Department decides against an applicant on "purely legislative-type issues" an adjudicatory hearing would not be required. [Compare Suburban Medical Center v. Olathe Community Hospital holding that SHCC review of a CON application is clearly a quasi-judicial function.]

b. Bayswater Health Related Facility v. New York Dept. of Health 394 N.Y.S.2d 314 (App.Div. 1977)

A partnership brought an action seeking judicial review of a state agency rescission of the agency's conditional approval of the partnership's application for a CON to establish a health-related facility. The state statute granted applicants whose projects the state agency proposed to disapprove the right to a public hearing. The state agency had conditionally approved the application and, upon the alleged failure of the applicant to meet the condition, advised it that the application was withdrawn. The state agency refused to provide a hearing on the theory that the application had not been disapproved. The Court rejected this theory and ruled that since contingent approval had clearly been given the state agency's only alternatives were to either approve the application or disapprove it and afford the applicant the opportunity to request a public hearing.

c. Cf. Thirteen Southfield Associates v. Department of Public Health 267 N.W.2d 483 (Mich.Ct.App. 1978)

A nursing home brought an action seeking a declaratory judgment that the state Department of Public Health was obligated to hold a hearing on its application for state certification to HUD of need for its project to construct a facility. State certification was a prerequisite to receipt of FHA mortgage insurance from HUD. The Court refused to compel the state to hold a hearing, holding that: (1) the federal law conditioning loan insurance on need certification did not require a hearing (12 USCA §1715w(d)(4)); and (2) state and federal constitutional due process clauses did not mandate a hearing because the nursing home did not have a prospective property interest in obtaining certification of need.

d. Hale v. Petit 438 A.2d 226 (Me. 1981), aff'g, No. C.V.81-2 (Me.Super.Ct. Kennebec County February 28, 1981)

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the granting of the other. The Court upheld the state agency's decision. In reviewing the plaintiff's allegations of procedural irregularity, the Superior Court held that the state CON review process, in which the applicant was not entitled to an administrative hearing by the state (although it was entitled to an HSA public hearing and might receive a "reconsideration hearing" by the state, following the state's decision, for good cause shown) did not violate due process. The trial court declined to directly adopt the reasoning of *Thirteen Southfield Associates, supra*, holding instead that in the balance of interests involved in CON a procedure which provides notice of the proceedings and review standards, an opportunity to (at the HSA public hearing and in writing) present the application, criticize competing applications and respond to criticism, and a reasoned final decision describing the basis for the action satisfies due process, notwithstanding the absence of an opportunity for cross-examination and swearing of witnesses. The Supreme Judicial Court agreed with the trial court's assessment of what process was due and with the court's conclusion that adequate procedures were provided.

7. Requirement of Comparative Review of Competing Applications

a. Section 1122 Cases

(1) *Cf. In re Basic American Medical, Inc.* 1122 RECONSIDERATION (letter from Robert Graham to Merrily Munther dated April 3, 1985)

A life care community requested DHHS reconsideration of a favorable determination of reimbursement under Section 1122 for its competitor's project to construct a life care community. The petitioner argued that the DPA erred in failing to comparatively review the project with its similar, contemporaneously-filed application, and requested DHHS to remand the application to the DPA for comparative review. DHHS declined to do so, observing that where, as here, the proponent of a capital expenditure gave timely notice and the DPA made a finding of conformity with the 1122 criteria, DHHS lacked the authority to look behind the finding of conformity and to remand the matter to the state.

DHHS also indicated that: (1) current federal Section 1122 law and regulations do not require DPAs to conduct comparative review or batching, nor do they prohibit a DPA from doing so to the extent consistent with such law and regulations; (2) Pub.L. 96-79 authorized DHHS to amend the federal Section 1122 regulations to require DPA comparative reviews [*See* Pub. H. Serv. Act §1532(b)(13)(A); 42 U.S.C.A. §300n-1 (b)(13)(A); 48 Fed. Reg. 36397 (1983) (*to be codified at* 42 CFR §125.109(a)) (proposed Aug. 10, 1983)]; and (3) Congress did not intend that any person other than the proponent of a capital expenditure have the right to appeal a DPA's finding of conformity. [*Compare* 48 Fed.Reg. 36399 (1983) (*to be codified at* 42 CFR §125.114(a), (b))(proposed Aug. 10, 1983).]

b. CON Cases

(1) Bio-Medical Applications of Clearwater v. Dept. of Health and Rehabilitative Services 370 So.2d 19 (Fla.Dist.Ct.App. 1979)

Bio-Medical Applications (BMA), a kidney dialysis center which had been denied a CON and a Section 1122 approval of its project to construct a 20-station dialysis center in the city of Clearwater, brought an action appealing the awarding of a CON for a dialysis center in the city of Clearwater to Kidneycare, its competitor. BMA sought a court order compelling the state agency to rehear the two applications in a comparative, consolidated proceeding.

The relevant proceedings began when the state agency initially disapproved Kidneycare's application, after which Kidneycare requested a hearing. BMA, whose application had by that time also been disapproved, and whose own hearing was pending, was permitted to intervene and participate in Kidneycare's hearing. However, its motion for consolidation of the two hearings was denied. Kidneycare's application was then fully approved at its hearing. Later, Bio- Medical's hearing resulted in an approval of only seven of its requested 20 stations.

The Court held that the state should have held a consolidated, comparative hearing on the two applications. (1) Whenever an applicant is able to show that the granting of authority to some other applicant will substantially prejudice his application, fairness requires that the agency conduct a comparative hearing in which the competing applications are considered simultaneously. Permitting an applicant to intervene and participate in the hearing on the competing application is insufficient since the merits of the intervenor's proposal are not thereby presented for comparative consideration. (2) In this case the applications were clearly competing, because they both proposed to satisfy an areawide need determined in accordance with a quantitative standard that had the effect of creating a fixed pool of needed investments. The granting of one application for a number of units automatically decreased need and effectively denied the other application to the extent of that number of units. (3) Comparative reviews of competing applications are required for fairness to applicants, are not unduly burdensome to the state agency (which should adopt a mechanism for determining when a comparative hearing is required), and advance the public interest by permitting comparative analysis of the cost effectiveness of projects. [The Court thus adopted for CON and 1122 review purposes the doctrine announced in Ashbacker Radio Corp. v. FCC 326 U.S. 327 (1945) in which the Supreme Court held that where two bona fide applications for administrative approval are mutually exclusive, the grant of one without a hearing to both deprives the loser of the hearing to which he is entitled-Ed.]

(2) Passaic General Hospital v. Finley Nos. A-3480-78, A-3791-78 (N.J.Super.Ct.App.Div. Mar. 27, 1980)

A hospital brought actions appealing the denial of its application for a CON to acquire a CT scanner and the contemporaneous awarding of a CON to a competitor. The HSA and the state agency thoroughly researched the applications together and the Court in this action consolidated plaintiff's appeal from the denial of its application with its appeal from the granting of the competitors' application. The Court held that this procedure afforded plaintiff a comparative consideration sufficient to satisfy the requirements of due process and the Ashbacker doctrine.

(3) Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission 312 N.W. 2d 422 (Mich.App. 1981), app.den. No. 68442 (Mich. Mar. 11, 1982)

A hospital corporation brought an action seeking judicial review of a state CON administrative appeals agency's decision denying its application for a CON to construct a new hospital. The appeals agency (the State Health Facilities Commission) heard appeals from initial CON decisions by the Department of Public Health. During the time it was reviewing the plaintiff's application the Department apparently knew that the existing facility in the area in which plaintiff planned to construct its facility was planning to file an application for a CON to replace its outdated facility. However, the existing facility's Notice of Intent was not filed until shortly after the Department denied plaintiff's application. By the time the Commission heard plaintiff's appeal, the Department had approved the existing facility's application.

The state agencies denied plaintiff's application on the basis of an unpublished criterion establishing a preference for existing facilities and replacement projects over new construction. The Court first held that the unpublished criterion was invalid. Then the Court held that the state erred in not according plaintiff a comparative hearing on its application and that of the existing facility because the record clearly established that the applications were mutually exclusive and in those circumstances principles of due process and administrative fairness required a comparative hearing. (Compare Huron Valley Hospital v. City of Pontiac, infra.)

The Court also ordered a CON issued to the plaintiff. It concluded that further proceedings would not remedy the errors which had occurred because: (1) during the pendency of the case the scope and purpose of the CON statute had been significantly amended, and (2) since the existing hospital had proceeded with its project, the state agency would have no choice consistent with the need criteria but to disapprove the plaintiff's application on remand. [Note: The existing hospital was able to proceed with its project (and render a comparative review on remand purposeless) because the Court, in Huron Valley Hospital, Inc. v. Michigan Department of Health 284 N.W.2d 758 (Mich.App. 1979) had dissolved a preliminary injunction obtained by Huron Valley Hospital enjoining the state agency from issuing a CON to the existing facility. In that opinion the Court of Appeals had concluded that the two applications were not mutually exclusive-Ed.]

(4) In re Behavioral Science Institute 436 A.2d 1329 (N.H. 1981)

An institute proposing to construct a new psychiatric hospital brought an action appealing the denial of its CON application. The institute filed its notice of intent on October 25, 1979, and its application on January 25, 1980. On February 12, 1980 Community Care Systems, Inc. (CCS) filed a notice of intent to construct a new psychiatric hospital. The state CON statute provided for "batching" (i.e., comparative review) of competing applications filed within 60 days after an application. CCS's application was not filed within 60 days after BSI's, and it was not designated as a competing application. BSI's application was initially approved by the state agency, then denied on reconsideration. On the same day that the state agency initially approved BSI's application it amended the need formula for psychiatric hospital beds in such a way as to make CCS's and BSI's applications mutually exclusive. On judicial review of BSI's denial the Court reversed, remanded the application to the state agency, and ordered the agency to comparatively review the applications. It held that CCS should have been treated as a competing applicant because: (1) although it failed to file within the 60-day period, it had filed an 1122 application putting the state agency on notice of its application, and (2) the change in the need criterion made the two applications mutually exclusive, requiring comparative review under the Ashbacker doctrine in order to insure fair treatment of both.

(5) Cf. Shelby County Hospital Board v. State Health Planning and Development Agency 443 So.2d 1239 (Ala. Civ. App. 1983) (Market competitor not "competing applicant"), infra p. 281.

(6) In re Certificate of Need Application by Community Psychiatric Centers, Inc. 676 P.2d 107 (Kansas 1984)

Two psychiatric hospital applicants, Excepticon and CPC, brought separate actions seeking judicial review of State

Agency (KDHE) denials of their applications to construct new facilities in Johnson County. KDHE concurrently reviewed the two applications but did not compare them. The State CON regulations provided for concurrent or batched comparative review of completed applications received during a particular review cycle. Although both applications were received during the cycle one was incomplete. The Court held that KDHE erred in concurrently reviewing the applications. However, the Court concluded that the error was harmless because KDHE denied both applications and did not compare them against each other.

(7) Cf. Federal Property Management Corp. v. Health Care and Retirement Corp. of America 462 So.2d 493 (Fla. Dist.Ct.App. 1984), infra p. 162.

8. Consolidation, Intervention, Etc., In Administrative Review Proceedings

a. See cases annotated in Section III.A.7. "Requirement of Comparative Review of Competing Applications," and Section III.A.19.a.(3) "Consolidation, Intervention, Etc., In Administrative Appeals."

b. Cf. Huron Valley Hospital, Inc. v. City of Pontiac 466 F.Supp. 1301 (D.Mich. 1979), vacated on other grounds, 666 F.2d 1029 (Sixth Cir. 1981) ("Huron v. Pontiac I")

An organization formed to build a new hospital in Pontiac brought an action against the SHPDA, the HSA, the City of Pontiac, and Pontiac General Hospital alleging a conspiracy to exclude it from the marketplace of providing hospital services in Pontiac. Plaintiff had applied for a CON to construct its facility and had been turned down. Several months later Pontiac General's application to replace its facility was approved. The District Court held that the plaintiff had no right under the fourteenth amendment due process clause to have participated in the hearing on Pontiac General's CON application since its own interest was by that time extinct and could not have been affected.

9. Conduct of Hearing & Other Proceedings

a. Olathe Hospital Foundation, Inc. v. Extendicare, Inc. 539 P.2d 1 (Kan. 1975)

Several hospitals brought an action for judicial review of a state agency appeals panel's final decision granting a CON to their competitor to construct a new hospital. The state sunshine act required open meetings of bodies like the appeals panel and provided that no binding action by such bodies could be decided upon by secret ballot. Following an all-day open meeting on the application the appeals panel met in closed session with the state agency director and an assistant attorney general and thereafter [apparently] the panel chairman announced that the panel had unanimously approved the application. The Court held that this procedure, while perhaps a technical violation of the sunshine act, was not so improper as to justify reversal.

b. Solari v. Annas No. 3164 (Mass.Super.Ct. Suffolk County July 2, 1976)

A ten-taxpayer group brought an action seeking judicial review of the decision of the Health Facilities Appeals Board (HFAB, a CON administrative appeals board) affirming the granting of a CON to renovate a hospital. The state agency held a "public hearing" on the application which was a "notice and comment" proceeding similar to that required for rulemaking under the state APA, with all parties given notice and an opportunity for their arguments to be heard and to bring legislative facts to the attention of the state agency. The plaintiffs claimed that the state agency should have held an adjudicatory proceeding at which an official record would be created and every party would have the right to call and examine witnesses, to introduce exhibits, to cross-examine witnesses, and to submit rebuttal evidence. The Court held that the "public hearing" procedures were constitutionally sufficient and consistent with the intent of the CON statute because: (1) the CON statute authorized the HFAB to review "materials on file with the department" in an appeal of a state agency decision to it, and if the law intended to require an adjudicatory hearing with an official record it would have authorized the HFAB to review such an "official record"; (2) CON applications typically do not involve "adjudicative facts" but instead represent policy decisions based on legislative facts (facts which do not concern the immediate parties but are general facts which help the tribunal decide questions of law and policy discretion); therefore adjudicatory proceedings are not necessary; and (3) even if an adjudicatory proceeding were required the allegedly less formal procedures employed by the state agency did not prejudice the substantial rights of any party.

c. Humana of Tennessee v. Tennessee Health Facilities Commission 552 S.W.2d 664 (Tenn. 1977)

A competitor brought an action seeking judicial review of a Health Facilities Commission decision granting a CON to construct a specialty care hospital. In reviewing plaintiff's allegations of procedural irregularities, the Court held that the denial to plaintiff of the opportunity for cross-examination of a witness at the area-wide health planning agency public meeting on the specialty care project application did not amount to reversible error because the witness was available and was cross-examined at a subsequent state hearing.

d. Hale v. Petit 438 A.2d 226 (Me. 1981), aff'g, No. C.V. 81-2 (Me.Super.Ct. Kennebec County February 28, 1981)

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the concurrent granting of a CON to the other applicant. The statutory state CON review process entitled an applicant to a public hearing at the HSA but not to an administrative hearing by the state. (The state could grant a reconsideration hearing but only for good cause). The trial court held that the CON review process, with no absolute right to a hearing before the ultimate decision-maker, did not deny due process. It also held that the fact that swearing of witnesses and cross-examination were not provided was not fatal to the proceeding because each side had sufficient opportunity to present its application, criticize the competing application, and comment on criticism of its own application to meet any constitutional due process test. In upholding the state agency's decision, the Supreme Judicial Court agreed with the trial court's assessment of what process was due and with the court's conclusion that adequate procedures were provided, adding that the plaintiffs had failed to demonstrate how they were prejudiced by the lack of cross-examination.

e. Mount Sinai Hospital v. Commission on Hospitals and Health Care No. CV-80-02406245 (Conn.Super.Ct. Hartford-New Britain Jud.Dist. Feb. 27, 1981)

A hospital brought an action seeking judicial review of the decision of the Commission on Hospitals and Health Care denying its application for a CON to acquire a CT scanner. The Commission on Hospitals and Health Care is a 17-member regulatory commission with the duty of, among other things, passing on CON applications. (1) The Commission's procedure on the hospital's CON application was to appoint a review panel from among its members to take evidence and propose a decision for action by the entire Commission. The Court held that the Commission had the authority under the state CON statute and APA to delegate the process of evidence-taking and preparation of a proposed decision to the panel. (2) The Commission had denied applicant's request that a transcript of the testimony before the review panel be furnished to the entire Commission. The Court held that the Commission acted arbitrarily and unfairly in failing to make the transcript available to all its members because without a transcript the members could not be expected to make an informed decision.

f. Humana Medical Corporation v. Schweiker No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. The Secretary of DHHS had administratively determined to exclude reimbursement for one year following a DPA recommendation that it do so. The hospital had been given the opportunity for written submissions on the Secretary's determination. The hospital requested and was granted reconsideration of the initial determination and was again given the opportunity to file a written submission. When the Secretary affirmed the initial determination, the hospital brought this action.

The hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc., discussed elsewhere in the GUIDE. The hospital argued that DHHS denied it due process by failing to give it a full-blown oral hearing initially and on reconsideration of the question of timely notice. The Court rejected this argument, holding that DHHS did not deny the hospital due process by giving it a paper hearing rather than a full-blown oral hearing initially and on reconsideration of the question of timely notice because under the procedural due process analysis of Matthews v. Eldridge, 424 U.S. 319 (1974): (a) the one-year exclusion of reimbursement is a minimal deprivation of property in the overall context of capital reimbursement; (b) a paper hearing on written submissions is fair and reliable where the evidence is documentary, oral testimony and confrontation is not needed and the hospital is well represented by counsel; and (c) oral hearings would be fiscally and administratively burdensome.

g. B.H.I., Inc. v. Connecticut Commission on Hospitals and Health Care No. 258137 (Conn.Super.Ct. Hartford - New Britan Jud.Dist. Dec. 22, 1982)

A convalescent home brought an action seeking judicial review of a Commission decision denying its application for a CON to convert into a psychiatric hospital. The Court ruled on several issues in upholding the Commission decision. On the hearing procedures issue, the Commission's procedure on the hospital's application was to appoint a three-member Review Panel from among its seventeen members to conduct a hearing, take evidence, and propose a decision for consideration and action by the entire Commission. The proposed decision contained a summary of each issue of fact or law necessary to reach the decision. The full Commission considered the proposed decision, the documentary evidence, plaintiff's written exceptions, and oral arguments before it, but did not view the transcript of the hearing before the Review Panel. The Court held that the failure of the full Commission to have the transcript before it did not deny the applicant procedural due process nor violate the state APA or the Commission's regulations because: (1) reading staff summaries is sufficient for deciding officers to understand the evidence; and (2) neither the APA nor the Commission's regulations required that the full Commission have the transcript. [Contra, Mount Sinai Hospital v. Commission on Hospitals and Health Care supra.] Finally, the Court found the Commission's denial supported by substantial evidence.

10. Ex Parte Contacts, Bias, and Conflict of Interest

a. Humana of Tennessee v. Tennessee Health Facilities Commission 551 S.W.2d 664 (Tenn. 1977)

A competitor brought an action seeking judicial review of a Health Facilities Commission decision granting a CON to construct a specialty care hospital. The Court held that ex parte contacts between Commission members and others were not such as to justify overturning the decision where there was no evidence that the information received materially affected the ultimate decision.

b. Cf. Lakeside Community Hospital v. Tahoe Regional Planning Agency 461 F.Supp. 1150 (D.Nev. 1978)

The proponents of a proposed hospital brought an action seeking judicial review of a bi-state compact agency decision denying their application for a permit to construct the facility in the Nevada portion of the agency's jurisdiction. The project had received a CON from the Nevada state health planning agency. One member of TRPA was also a member of the board of directors of the local Nevada HSA, which presented evidence at the TRPA hearing, and apparently other TRPA members had been exposed to evidence pertaining to need for the facility in unrelated investigatory proceedings. The Court held that the TRPA decision was not tainted by impermissible bias in violation of the procedural due process rights of the plaintiffs by virtue of the foregoing contacts and relationship because there was no evidence or allegations that any member of the TRPA board entertained a personal bias or prejudice against the plaintiff or had any pecuniary interest in the dispute or its resolution.

c. Suburban Medical Center v. Olathe Community Hospital 597 P2d 654 (Kan. 1979)

A competitor brought an action to review a SHCC decision granting a CON to a community hospital for a project to expand its facilities and add beds. The Court held that improper contacts between SHCC members and hospital "boosters" (staff, board members, committees, elected officials, and other citizens) rendered a fair decision impossible and required reversal.

d. West Virginia Health Systems Agency v. State Health Planning and Development Agency No. AP-CA-80-1 (W.Va. Cir.Ct. Kanawha County July 2, 1980)

An HSA brought an action seeking judicial review of the decision of the state Tax Department (the designated agency for hearing administrative CON appeals) to award a CON for construction of a replacement hospital facility. The HSA had recommended disapproval. The HSA alleged that improper ex parte contacts had taken place in the course of state agency review including personal interference by the Governor on behalf of the applicant. The Court indicated that out of an abundance of caution it held an evidentiary hearing on the issue. The Court then held that the HSA failed to produce sufficient evidence of improper ex parte contacts to rebut the presumption of procedural regularity and override the "mental process" rule.

e. Hale v. Petit No. C.V.81-2 (Me.Super.Ct. Kennebec County February 28, 1981), aff'd, 438 A.2d 226 (Me. 1981)

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the concurrent granting of a CON to the other applicant. In reviewing the plaintiff's allegations of procedural irregularities the trial court and State Supreme Court on appeal held that ex parte contacts in the form of significant data submissions and clarifications between the successful applicant and the SHPDA staff after the HSA public hearing but before the SHPDA decision [there was no SHPDA hearing in the course of review in this state - Ed.] did not indicate bias or prejudice invalidating the final decision. The trial court based its holding on the fact that the final SHDPA decision-maker, the Commissioner of Human Services, did not participate in and was not biased by the contacts. The Supreme Judicial Court affirmed, noting that: (1) the state CON statute provides for a hearing "in the course of review" suggesting that the state may continue to accept new material after the hearing before making its decision; and (2) state regulations specify that applicants may submit revised applications at any time before the state makes its initial decision.

f. Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission No. 80-200439-AA (Mich.Cir.Ct. Oakland County March 27, 1981), aff'd on other grounds, 312 N.W.2d 422 (Mich.App. 1981), app.den. No. 68442 (Mich. Mar. 11, 1982)

A hospital corporation brought an action seeking judicial review of a state CON administrative appeals agency's denial of its application for a CON to construct a new hospital. The Commission rendered final decisions on CON applications and also advised the state Division of Health Facilities Planning and Construction on the development of the SHP. The SHP was a criterion in CON. The hospital claimed that the dual role of the Commission arising out of its involvement with the development of the SHP and subsequent use of the SHP in CON review created an unacceptable risk of potential bias violating the hospital's constitutional right to a fair hearing before an impartial tribunal. The Court rejected this argument holding that the limited role of the Commission vis-a-vis the SHP, the technical, statistical nature of the SHP, and the structure of the Commission's role were such as to indicate no unconstitutional risk of potential bias.

g. Mercy Medical Center v. Idaho Health Facilities Review Board No. L-35732 (Idaho Dist.Ct., Canyon County, July 28, 1982)

A competitor brought an action seeking to overturn the decision of the Idaho Health Facilities Review Board (the state's CON decision-maker) awarding a CON to its competitor to construct an ambulatory surgicenter. The Review Board had initially voted to deny the application. On administrative appeal an Appeals Board had remanded the decision for a new vote, because the Review Board members failed to affirm when voting that their vote was based solely on the record, as required by Review Board regulations. Then, on remand the Review Board reversed itself and approved the application. The Court held as follows: (1) The plaintiff failed to exhaust its administrative remedy of appealing the Review Board's second decision to the Appeals Board. The Court nevertheless reached the issues raised by the plaintiff. (2) The fact that two of the three members of the Appeals Board were also members of the Review Board (who had both voted against the plaintiff's motion before the Review Board to deny the application) did not indicate bias on the Appeals Board amounting to a denial of plaintiff's due process rights because: (a) the right to oppose the issuance of a CON by a person operating a competing health care facility is a constitutionally protected property interest; and (b) the Appeals Board action does not appear to have been affected by bias because the Appeals Board did not vote to reverse the Review Board, it merely voted to remand the application to the Review Board to correct a voting procedure deficient under Review Board rules. (3) The fact that the Review Board voted a second time on the application did not deny plaintiff due process because: (a) the original vote being flawed, there was in legal result no supportable vote; and (b) both before the initial and second votes the Review Board gave notice of hearing to affected parties and the public, held a hearing and reached a final decision based upon evidence.

h. North Fulton Community Hospital, Inc. v. State Health Planning and Development Agency 310 S.E.2d 764 (Ga. App. 1983)

A new hospital project proponent brought an action seeking judicial review of a SHPDA decision, affirmed by the State Health Planning Review Board (SHPRD), an administrative appellate panel, denying its application for a CON to construct the new hospital. The hospital alleged, inter alia, that the SHPRD hearing and decision-making process denied it due process because one Assistant Attorney-General represented both the SHPDA and the SHPRD in the proceeding.

The Court ruled on several aspects of the Assistant Attorney-General's dual representation of the SHPDA and the SHPRD. The SHPDA ex parte contacts regulation provided that:

> No applicant or other party on behalf of or in opposition to an applicant shall contact, outside of a duly constituted appeal hearing, any member or members of the [SHPRD] to discuss any aspect of a project or an appeal.

Because the SHPDA and the SHPRD were both state agencies, the Attorney-General was required by law to represent both. At the SHPRD hearing on the hospital's application the Assistant Attorney-General appeared on behalf of the SHPDA, a party. During the course of the hearing the SHPDA established a pattern of seeking the views of counsel for all parties, either by brief or by conversation, before ruling on issues affecting the course of the proceedings. In addition, the Assistant Attorney-General advised the SHPRD from time to time when specifically requested to do so. He had contacts with the SHPRD outside the hearing relating to a standing question, the legal effect of a legislative resolution, the manner of SHPRD vote-taking, and the preparation of findings of fact and conclusions of law after the SHPRD decision had been announced.

Initially, the Court held that the Assistant Attorney-General's dual representation was not prejudicial per se to the hospital, and that the dual representation did not in fact deprive the hospital of a fair hearing because the SHPRD: (1) did not substantially rely on the Assistant Attorney-General for legal advice, seeking instead the views of all counsel including the Assistant Attorney-General; and

(2) the SHPRD's many rulings during the hearing showed no pattern of deference to the Assistant Attorney-General.

Next, the Court ruled that the ex parte contacts between the Assistant Attorney-General and the SHPRD did not render the decision void because: (1) ex parte contacts by an attorney with legally-mandated dual representation responsibilities are not per se illegal since if an advocate is lawfully mandated to represent dual interests in an administrative hearing, some ex parte contact is inherent in the relationship; (2) the contacts between the Assistant Attorney-General and the SHPRD did not violate the SHPDA ex parte contacts regulation because the regulation only forbade contacts by a "applicant" or by a "party on behalf of or in opposition to an applicant" and the contacts complained of were neither made by an applicant nor made to advance or deter the cause of any applicant; and (3) the contacts did not, in fact, deprive the hospital of a fair hearing because the content of the Assistant Attorney-General's advice and the rulings of the SHPRD on the matters about which advice was sought were not prejudicial to the fair conduct of the hearing, and did not affect the full and fair consideration of the hospital's case by SHPRD. The Court specifically noted that it was not improper for the Assistant Attorney-General, who was counsel for the prevailing party, to assist the SHPRD in preparing findings after the decision had been reached.

i. Rehab Hospital Services Corp. v. Health Systems Agency of Southwestern Pennsylvania 475 A.2d 883 (Pa. Cmwlth. 1984)

A hospital and a state Health Department brought an action seeking judicial review of a state CON appeals board's decision overturning the Secretary of Health's approval of the hospital's CON application to construct a rehabilitation hospital. The Secretary's approval, which was inconsistent with the recommendation of the HSA and the SHPDA staff, was based in part on project per diem costs lower than existing facilities and was intended to foster competition in an area where rehabilitation services were often provided in acute care hospitals at a much greater cost. The state CON statute contained an express legislative purpose to, among other things, encourage innovation and improved delivery methods. It also required that all Health Department decisions be based solely on the record. The Court held that the fact that the Secretary's decision was based on policy considerations and his own subjective knowledge and years of experience did not mean that it was improperly based on extra-record matters because the Secretary was expected to utilize the experience and background for which he was chosen for office. His use of subjective knowledge would not render his decision improper if the decision was based upon information present within the record.

11. HSA Review Proceedings

a. Humana of Tennessee v. Tennessee Health Facilities Commission 552 SW.2d 664 (Tenn. 1977)

A competitor brought an action seeking judicial review of a state agency decision granting a CON to construct a specialty care hospital. A public hearing was held before the HSA for the health service area in which the proposed facility would be located. The plaintiff alleged that a hearing should have been held by the HSA for the adjacent area, from which the proposed facility might receive patients. The Court held that such a hearing was not required because the state CON statute provided for public hearings by only one area agency. The Court also held that the denial to plaintiff of the opportunity for cross-examination of a witness at the area-wide health planning agency public meeting did not amount to reversible error because the witness was available and was cross-examined at a subsequent state hearing.

b. Hale v. Petit 439 A.2d 226 (Me. 1981), aff'g, No. C.V.81-2 (Me.Super.Ct. Kennebec County February 28, 1981)

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the concurrent granting of a CON to the other applicant. The statutory state CON review process entitled an applicant to a public hearing at the HSA but not to an administrative hearing by the state. (The state could grant a reconsideration hearing, but only for good cause). The Court upheld the state agency decision, holding among other things that the HSA public hearing and state agency reconsideration hearing processes were not subject to the state APA provisions governing administrative adjudications because the statutory scheme of the CON law as a whole was so inconsistent with the procedures set forth in the state APA as to indicate a legislative intent that the APA not apply.

The plaintiff argued that its due process rights were violated by the conduct of the HSA public hearing. The trial court rejected this argument holding that the fact that swearing of witnesses and cross-examination were not provided was not fatal to the proceeding because each side had sufficient opportunity to present its application, criticize the competing application, and comment on criticism of its own application to meet any constitutional due process test. The Supreme Judicial Court agreed with the trial court's assessment of what process was due and with the court's conclusion that adequate procedures were provided.

12. Burden of Proof and Burden of Producing Evidence

a. Texas Health Facilities Commission v. Baptist General Convention 573 S.W. 2d 575 (Tex.Civ.App. 1978)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to add five upper floors to an existing hospital building to be shelled in for later completion. The state CON criteria provided in part:

> (a) The commission shall promulgate rules establishing criteria to determine whether an applicant is to be issued a certificate of need for the proposed project. (b) Criteria established by the commission must include at least the following: (1) whether a proposed project is necessary to meet the health-care needs of the community or population to be served; (2) whether a proposed project can be adequately staffed and operated when completed; (3) whether the cost of the proposed project is economically feasible; (4) if applicable, whether a proposed project meets the special needs and circumstances for rural or sparsely populated areas; and (5) if applicable, whether the proposed project meets special needs for special services or special facilities.

The Court held that the language of the statute indicated that the first three criteria must be affirmatively satisfied by evidence.

b. Texas Health Facilities Commission v. Nueces County Hospital District 581 S.W.2d 768 (Tex.Civ.App. 1979)

A hospital brought an action appealing the denial of its application for a CON to acquire a CT scanner and the awarding of a CON to its competitor. The Court observed that the hospital, as an applicant, had to produce evidence in the agency hearing showing a need in the community for a scanner at its hospital.

c. Samuel Merritt Hospital v. Advisory Health Council 1 Civil 48646 (Ca.Ct.App. Mar. 27, 1981)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to acquire a CT scanner. The state criterion for review of CT scanner applications provided that the applicant must demonstrate need by clear and convincing evidence and that:

> Evidence of such need shall be that the applicant hospital is currently performing at least 30,000 general radiographic imaging procedures per year, and at least one of the following: (A) The applicant hospital has a licensed bed capacity of at

least 250 beds. (B) For a head scanner, there is a population in the service area of at least 150,000 which is currently unserved by a scanner capable of performing head scans; or, for a body scanner, there is a population in the service area of at least 300,000 which is currently underserved by a body scanner.

The Court held that the import of the foregoing language was that the presentation of evidence of 30,000 imaging procedures and 250 beds, etc., would create a rebuttable presumption of need. In the absence of contravening evidence, the need may be regarded as established. However, where other evidence of the lack of need is presented, the need may no longer be presumed from the performance and the capacity. These facts are then merely taken into consideration, together with all the other evidence, in the determination of need. In other words, the regulation establishes a presumption affecting the burden of producing evidence, not a presumption affecting the burden of proof.

d. Mid-Ohio Health Planning Federation v. Certificate of Need Review Board No. 81AP-958 (Ohio.Ct.App. Franklin County, April 1, 1982)

An HSA brought an action seeking judicial review of a SHPDA decision, affirmed on administrative appeal by the state CON Review Board, that a CON be awarded for a hospital replacement/relocation project.

The Court upheld the SHPDA decision, making a number of rulings on procedural and substantive issues. The Court ruled on the application of the burden of proof in CON proceedings as follows: The state CON statute provided that the burden of proof in the review process shall be upon the applicant (Ohio R.C. 3702.54(A) (1980)). According to the state CON statute, administrative review proceedings before the CON Review Board were conducted in accordance with the State APA under which the usual rule was that the party asserting an affirmative issue bore the burden of proof. Apparently concluding that the proceedings before the CON Review Board were appellate in nature (the Court noted that the hearing was not specifically stated to be a de novo proceeding and that it was reasonable and logical for the proceeding to be directed only to the areas where the appellant felt prejudicial error had occurred), the Court ruled that in such proceedings the appellant HSA had the burden of proving error by the SHPDA for all issues raised except for demonstration of need, as to which the applicant had the burden throughout the review process under R.C. 3702.54(A). The Court also ruled that it was not improper to place the burden of producing evidence entirely upon the appellant who requested the adjudication hearing before the CON Review Board.

a. Rainbow Community Hospital, Inc. v. Dept. of Health and Rehabilitative Services 453 So.2d 1200 (Fla. Dist. Ct. App. 1984)

A hospital brought an action seeking judicial review of a SHPDA denial of its application for a CON to construct a new osteopathic hospital. The Court held that although the state had failed to construe the osteopathic hospital need criterion properly the error was harmless because the applicant had failed to satisfy its burden of proving such need by competent substantial evidence.

13. Administrative Record.

a. Olathe Hospital Foundation, Inc. v. Extendicare, Inc. 539 P.2d 1 (Kan. 1975)

Several hospitals brought an action for judicial review of a state agency appeals panel's final decision granting a CON to their competitor to construct a new hospital. The Court upheld the trial court's refusal to admit the testimony of an expert in health planning, ruling that although the courts may take additional evidence on the issue of whether the administrative decision was arbitrary and capricious it cannot retry the merits of the application and permit the hospitals to produce part of their evidence before the administrative agency and then produce the balance on judicial review.

b. Stamford Hospital v. Commission on Hospitals and Health Care No. 17334 (Conn.Ct.C.P. Fairfield County Jan. 27, 1978)

A hospital brought an action appealing the decision of the state agency denying its application for a CON to acquire a CT scanner. In the course of a hearing on the hospital's application, state commission members indicated that they were considering evidence produced at prior hearings on other applications in considering the hospital's application. The Commissioners did not provide any other identification of this evidence. The Court held that the Commission erred in taking official notice of facts produced in prior applications without notifying the hospital of the materials noticed because although the Commission had the right to use its specialized knowledge to evaluate whatever evidence the hospital submitted, the state APA and the Commission's rules required it to notify the applicant of facts to be officially noticed.

c. Texas Health Facilities Commission v. Nueces County Hospital District 581 S.W.2d 768 (Tex.Civ.App. 1979)

A hospital brought an action appealing the granting of a CON to acquire a CT scanner to its competitor and the denial of its application. [The trial court severed the two causes of action. This case concerns the hospital's appeal of the denial of its application. Its appeal of the award to the competitor is considered in Nueces County Hospital District v. Texas Health Facilities Commission.] The Court indicated that the appeal was governed by the "substantial evidence" standard of review. All the evidence in the record was that there was a need for two scanners. No witness testified that only one scanner was needed. The state agency acknowledged this fact but argued that it had the authority to utilize its special skills and knowledge in evaluating the evidence and to deny the application on that basis. The Court overturned the state agency denial because the state agency had failed to explain the role played by such special skills and knowledge in the findings and a valid exercise of agency expertise, like other agency action, must find support in substantial evidence in the record made before the agency.

d. Rehab Hospital Services Corp. v. Health Systems Agency of Southwestern Pennsylvania 475 A.2d 883 (Pa. Cmwlth. 1984)

A hospital and a state Health Department brought an action seeking judicial review of a state CON appeals board's decision overturning the Secretary of Health's approval of the hospital's CON application to construct a rehabilitation hospital. The Secretary's approval, which was inconsistent with the recommendation of the HSA and the SHPDA staff, was based in part on project per diem costs lower than existing facilities and was intended to foster competition in an area where rehabilitation services were often provided in acute care hospitals at a much greater cost. The state CON statute contained an express legislative purpose to, among other things, encourage innovation and improved delivery methods. It also required that all Health Department decisions be based solely on the record. The Court held that the fact that the Secretary's decision was based on policy considerations and his own subjective knowledge and years of experience did not mean that it was improperly based on extra-record matters because the Secretary was expected to utilize the experience and background for which he was chosen for office. His use of subjective knowledge would not render his decision improper if the decision was based upon information present within the record. Compare Texas Health Facilities Commission v. Nueces County, supra.

e. Collier Medical Center, Inc. v. Dept. of Health and Rehabilitative Services 462 So.2d 83 (Fla. Dist. Ct. App. 1985)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a certificate of need to construct a new hospital which would serve two counties. Three existing competitor hospitals in the two counties, one of which also operated a "primary care center emergency room" in the area and the other two of which had large charity case loads, had been permitted to intervene in the hospital's administrative hearing as persons whose "substantial interests" were affected by the proposed agency action. The Court upheld the agency decision holding, among other things, that the state agency hearing officer did not err in refusing to allow the hospital to supplement the record four months after the hearing by introducing notices of intent filed by one of the competitors to expand and construct satellite hospitals in the proposed facility's area. There was no evidence when the applications for the noticed projects would be reviewed and post-hearing production of evidence was disfavored. The hospital had sought to introduce the notices to show that the competitors' motive for intervening was protection of their monopoly over medical service in the area.

14. Form of Decision on CON Application

a. St. Vincent's Hospital v. Finley 380 A.2d 1158 (N.J. Super.App.Div. 1977)

A hospital brought an action seeking judicial review of a state agency appeals board's decision denying its application for a CON to construct a new facility. The state Commissioner of Health had recommended denial of the application giving reasons in a letter dated April 24, 1975. The hospital appealed to the Health Care Appeals Board (HCAB). A hearing took place and the hearing officer prepared a report which recommended approval and made findings that each of the Commissioner's reasons was unsupported by the evidence in the record. The HCAB then disapproved the application itself in a written decision which repeated verbatim the reasons in the Commissioner's April 24, 1975 letter and did not refer at all to the Hearing Officer's decision. The Court held that the HCAB decision contained insufficient findings of fact and conclusions of law to permit meaningful judicial review because the reasons in the decision were identical to those in the Commissioner's letter and thus the record was entirely barren of any indication as to how, if at all, the HCAB evaluated the proofs before the hearing officer or his report and recommendation.

b. Olathe Hospital Foundation, Inc. v. Extendicare, Inc. 539 P.2d 1 (Kan. 1975)

Several hospitals brought an action seeking judicial review of a state agency appeals panel's final decision granting a CON to their competitor to construct a new hospital. The hospitals complained that the appeals panel failed to make specific findings of fact and merely announced the result of its vote through its chairman. The Court held that although specific findings by administrative agencies were desirable there was no statute or rule requiring the agency to adopt findings, and in the absence of a rule or statute the agency was not required to adopt them.

c. Los Alamitos General Hospital v. Lackner 86 Cal.App. 3d 417, 149 Cal.Rptr. 98 (1978)

A hospital brought an action seeking judicial review of the decisions of the state agency severing the CT scanner acquisition component of its radiology department remodeling project from the rest of the application for the project, approving the non-severed component under a grandfather exemption, and denying the severed component both a grandfather exemption and a CON. The Court reversed and remanded, holding that: (1) implicit in the state statute providing for judicial review of administrative decisions is a requirement that the agency which renders the challenged decision must set forth findings to bridge the analytic gap between the raw evidence and the ultimate decision order; and (2) the state agency failed to satisfy this requirement because its findings failed to make it clear whether it severed a portion of the project because it believed it had unqualified power to do so (in which case its decision would be reversed) or because it made a factual determination that the severed portion was actually a separate project (in which case its decision would be upheld as a factual determination supported by substantial evidence). Because the findings failed to specifically address this issue the Court remanded the case to the agency for further findings of fact.

d. Home Health Agency Assembly of New Jersey, Inc. v. Homemakers International Co. No. A-3667-76 (N.J.Super. Ct.App.Div. June 23, 1978)

An organization of certified and/or licensed home health agencies in the state and several individual non-profit home health agencies brought an action appealing the decision of the Commissioner of Health granting a CON to Homemakers International to provide home health services in areas presently served by the individual agencies. The Court ordered the matter remanded to the Commissioner because her decision did not contain findings of fact relating to each of the statutory criteria and factors, nor expressions of the reasoning which, applied to the found facts, led to the decision. Consequently, the Court was unable to determine the course by which and the basis upon which she arrived at her conclusion.

e. Cf. Texas Health Facilities Commission v. Nueces County Hospital District 581 S.W.2d 768 (Tex.Civ.App. 1979)

A hospital brought an action appealing the granting of a CON to acquire a CT scanner to its competitor and the denial of its application. [The trial court severed the two causes of action. This case concerns the hospital's appeal of the denial of its application. Its appeal of the award to the competitor is considered in Nueces County Hospital District v. Texas Health Facilities Commission.] The Court indicated that the appeal was governed by the "substantial evidence" standard of review. All the evidence in the record was that there was a need for two scanners. No witness testified that only one scanner was needed. The state agency acknowledged this fact but argued that it had the authority to utilize its special skills and knowledge in evaluating the evidence and to deny the application on that basis. The Court overturned the state agency denial because the state agency had failed to explain the role played by such special skills and knowledge in the findings and a valid exercise of agency expertise, like other agency action, must find support in substantial evidence in the record made before the agency.

f. Oklahoma Pioneer Inc. v. Carpenter 617 P.2d 210 (Okla. 1980)

A competitor brought an action seeking judicial review of the decision of the state agency granting its competitor a CON for a project to add beds to a nursing home. A CON was issued but without findings of fact or conclusions of law until after appellant filed petition for review. The Court held that: (1) the state APA required written findings when a final order was adverse to a party; and (2) the filing of a petition for review divested the SHPDA of authority to supplement the record with findings. The Court remanded to the SHPDA to conduct a new hearing on the application.

g. Hale v. Petit 438 A.2d 226 (Me. 1981)

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the concurrent granting of a CON to the other applicant. The state agency denial consisted of a one-page letter summarizing the state's reasons for not choosing the proposal, accompanied by the state agency staff report which contained a detailed comparison of the two projects. The Court upheld the state agency decision, holding that the state agency decision satisfied the statutory requirement that the notice to the applicant explain the basis for the decision because the staff report was thorough and well-organized, the letter summarized the report's main points, and together they sufficiently appriced the applicant and the public of the basis for decision and allowed for judicial review.

The state statute also required the state agency to give a detailed statement of reasons for inconsistency between the state decision and the HSA recommendation. The HSA had recommended approval of the disappointed applicant's project. The state agency decision failed to compare its reasoning with that of the HSA. The Court held that the state agency decision was not improper because: (1) the HSA failed to provide any explanation for its decision; and (2) the requirement of a statement of reasons is intended to protect against arbitrary state action and the detailed staff report indicated that the state did not act arbitrarily.

h. Mid-Ohio Health Planning Federation v. Certificate of Need Review Board No. 81AP-958 (Ohio.Ct.App. Franklin County, April 1, 1982)

An HSA brought an action seeking judicial review of a SHPDA decision, affirmed on administrative appeal by the state CON Review Board, that a CON be awarded for a hospital replacement/relocation project.

The Court upheld the SHPDA decision, making a number of rulings on procedural and substantive issues. First, the Court held that the SHPDA's findings on the applicant's compliance with certain review criteria, for which written findings were required, were legally sufficient. The state CON statute required the SHPDA to make any findings required by NHPRDA and in addition written findings of fact on compliance with certain other review criteria. The SHPDA's findings of fact consisted of selected quotations or paraphrases of the language in the federal regulations or state statute, followed by the statement, "This finding can be made." The Court held that these findings were legally sufficient because: (1) the federal regulations (42 CFR §123.410 (1979)) which required "written findings" or "findings in writing" as to certain specified matters did not require a specific factual finding and a general finding in the exact words of the law was sufficient; (2) even if the general findings could be found to be technically insufficient, it would be an exercise in futility to remand the case to the SHPDA to specifically make a required finding if the required finding would be justified by the evidence and all of the reviewing bodies including the Court were able to reasonably discern the basis upon which the SHPDA made its finding; and (3) as to some of the matters for which findings were required, more specific findings of fact were made by the CON Review Board's hearing officer following the SHPDA decision and were adopted by the Board.

Second, the state statute provided that if the SHPDA decision was inconsistent with the HSA's findings and recommendation the SHPDA was required to include within its written findings the criteria and statistical measures it used in making its determinations. The SHPDA did not do so, but it did deliver the SHPDA staff report containing a lengthy discussion of the criteria and statistical measures to the HSA. The Court held that this actions satisfied the statutory purpose of stating a statistical basis for the SHPDA's difference with the HSA and informing the HSA of that basis, and any technical error was harmless.

i. In re Rev. of Dec. of Kansas Corp. Com'n 659 P.2d 199 (Kan. 1983)

A competitor brought an action appealing the decision of KCC, the state CON administrative appeals body, to grant a CON to Providence-St. Margaret Health Center to acquire a 6MeV linear accelerator. KCC had reversed the SHPDA denial of the application. The Court reversed KCC and ordered the application denied, holding, among other things, that the trial court erred when, in upholding KCC's decision, it found KCC's ultimate finding that there was a need for the project to be implicit in KCC's granting of the CON. The Court held that the lack of express findings by an administrative agency may not be supplied by implication. [KCC's decision, quoted in the Supreme Court opinion, dealt with the issue simply by finding insufficient evidence to support the SHPDA's finding of absence of need.]

j. Texas Health Facilities Commission v. Charter Medical-Dallas, Inc. 665 S.W.2d 446 (Tex. 1984) rev'g 656 S.W.2d 928 (Tex.Ct.App. 1983)

A psychiatric hospital brought an action seeking judicial review of a THFC decision in a comparative review denying it a CON to construct a new facility and granting CONs to two other applicants for psychiatric facilities or units. THFC's decision on the hospital's application found that it failed to satisfy several review criteria, including the need criterion. The state CON statute required THFC to adopt review criteria, and to include among its criteria five factors of community need, adequate staffing, economic feasibility, special needs of rural areas, and special needs for special services/facilities. THFC had adopted regulations setting forth review criteria or ultimate factors in thirteen broad categories, incorporating the aforementioned factors, and approximately fifty-four subcategories that THFC considered relevant to its decision on the ultimate factors. The state APA provided that an agency decision may be reversed if it is arbitrary and capricious or not supported by substantial evidence. It also required that there be findings of fact included in a decision, accompanied if the findings were set forth in statutory language by a concise and explicit statement of the underlying facts supporting the findings.

The Court of Appeals held that THFC's decision was arbitrary and capricious because its ultimate findings were not accompanied by basic facts or underlying factual determinations based on the evidence, including basic facts distinguishing Charter from the approved applicants. The Supreme Court reversed, holding that: (1)(a) By providing that THFC must adopt review criteria including the five factors the state CON statute required ultimate fact findings as to those five factors; (b) the state APA required a concise and explicit statement of underlying facts supporting such mandatory ultimate fact findings; (c) underlying findings of fact should be clear, specific, non-conclusory and supportive of the ultimate statutory finding. Mere recitals of testimony or references to or summations of the evidence are improper. The findings should be stated as the agency's findings, should relate to material basic facts and should relate to the ultimate statutory finding they accompany; and (d) THFC's 500 findings of fact covering approximately 48 pages contained many findings not satisfying the foregoing requirements because they were nothing more than recitals of evidence but they also contained proper ultimate findings as to the five factors and sufficient findings so that the Court could fairly and reasonably say that the underlying or basic facts supported THFC's ultimate findings. (2) There was substantial evidence in THFC's underlying findings of fact to support its ultimate finding that Charter failed to satisfy the community need criterion including the following: Charter would not be near or connected with a general hospital and ambulance service would be required to transfer a patient to a general hospital for medical treatment; Charter would not be accessible by public transportation; Charter failed to establish as great physician interest in its facility as the other two facilities; Charter failed to support its projected occupancy rates with competent evidence; certain recreational facilities would probably be absent at Charter; Charter unnecessarily duplicated certain specified services and equipment; and the local HSA issued a negative report on Charter. (3) THFC's decision was not arbitrary and capricious.

k. Bradbury Memorial Nursing Home v. Tall Pines Manor Associates 485 A.2d 634 (Me. 1984)

A nursing home (Bradbury) brought an action seeking judicial review of the issuance of a CON to its competitor (TP) for new nursing home construction. Bradbury had previously unsuccessfully sought administrative reconsideration of the TP approval. The Court upheld the state agency, holding, among other things, that the state agency did not fail to give reasons for its decision or provide a statement of reasons for the inconsistency between its decision and the HSA recommendation. The Court held that the state agency's letter to TP granting the CON was less than a full explanation but the agency remedied the deficiency by explaining its decision in its response to Bradbury's reconsideration request and the Department's statement of its reasons at any time before its decision became final fully satisfied its statutory obligation.

1. Texas Health Facilities Commission v. Presbyterian Hospital North 690 S.W.2d 564 (Tex. 1985), aff'g 664 S.W.2d 391 (Tex.Civ.App. 1984)

A hospital brought an action seeking judicial review of a THFC decision denying its application for a CON to construct a new facility. The hospital's project had been concurrently reviewed with five other hospital construction proposals for the same vicinity, all of which were approved. THFC found that the proposed project did not meet the review criteria of: (1) need in the community to be served; (2) sufficient current and future area population to require the facility; and (3) a criterion requiring that the project's approach to providing health care services be "less costly, or more effective or more appropriate" than other available or approved approaches. The state APA required that administrative agency "ultimate findings" (e.g. conclusions of law as to whether individual review criteria have been met) be accompanied by a concise or explicit statement of the underlying facts supporting the ultimate findings or conclusions. (Texas Administrative Procedure and Texas Register Act §16(b)). The agency decision in this case set forth findings of underlying fact to support each of its conclusions in the form of lengthy summaries of all the testimony and documentary evidence relevant to the criterion in question. The Court remanded the case to THFC, holding that the agency's findings of fact in the form of recitals of the evidence were defective, citing Texas Health Facilities Commission v. Charter Medical-Dallas, Inc., and holding that when such defective findings were discarded the Court was unable to fairly and reasonably conclude that the remaining underlying fact findings supported THFC's ultimate findings on the statutory criteria.

15. Preliminary, Tentative, and Proposed Decisions

a. Bayswater Health Related Facility v. New York State Department of Health 394 N.Y.S 2d 314 (App.Div. 1977)

A partnership brought an action seeking judicial review of a state agency rescission of the agency's conditional approval of the partnership's application for a CON to establish a health related facility. On April 23, 1971, the Public Health Council approved the application subject to a financing condition to be met within 120 days. In February, 1975, the Council notified the applicant that its failure to meet the financing condition constituted a withdrawal of the application and rendered the prior approval null. On

July 18, 1975, the Council reinstated the approval on the condition that the applicant commence construction within 45 days. On December 19, 1975, the Council once again notified the applicant that its application was deemed withdrawn apparently for failure to meet the financing condition. The Court held that the Council's action in deeming the application withdrawn was arbitrary and capricious because the July 18, 1975, directive from the Council had not set forth any time limit on the financing condition, the applicant had complied with the other conditions imposed by that directive (undertaking large expenditures and contractual liabilities in reliance thereon), and therefore to permit "withdrawal" would: (1) render the July 18 directive meaningless; (2) permit the Council to penalize delay while ignoring the condonation of that delay by the Council; and (3) unfairly discount the expenditures incurred in reliance on the July 18 directive.

b. Cf. Bureau of Community Medical Facilities v. Samson 341 So.2d 1071 (Fla.Dist.Ct.App. 1977)

A DPA brought an action seeking judicial review of the decision of a hearing officer reversing the DPA's recommendation of denial of reimbursement under Section 1122 of a project to construct a new hospital. The state's Section 1122 contract required the DPA to comply with the federal Section 1122 regulations including providing disappointed applicants with a fair hearing before a hearing officer whose decision superseded the findings and recommendations of the DPA (42 CFR §100.106(c)(2), (4)(1976)). However, the state APA secured judicial review only of "final agency action." The Court held that judicial review of the hearing officer's decision was not available because the hearing officer's decision technically could not be the final agency action. Thus, the DPA must take the final action following the hearing officer's decision by either recommending denial or approval. If the DPA recommends denial it violates its 1122 contract, the Court observed. And if it recommends approval it will then lack standing to seek judicial review as a "person adversely affected."

c. Hamptons Hospital and Medical Center v. Moore 417 N.E.2d 533 (N.Y. 1981)

A hospital brought an action to enjoin the state agency from reconsidering its prior determination regarding the hospital's application for a CON to construct a new hospital. In 1972 the Public Health Council had passed a resolution proposing to approve the application subject to certain financing conditions. The applicant never secured proper financing and in 1977 the Council reevaluated the need for the project and proposed to disapprove. The Court held that: (1) the 1972 resolution was on its face merely a tentative proposal to approve, subject to reconsideration at any time; (2) given the Council's obligation to give final approval to only those projects found to be needed, a re-evaluation of need for the project was in order because considerable time had elapsed since the initial determination of need; and (3) the Council should not be equitably estopped or prevented from re-evaluating the question of public need on the grounds that the applicant, in detrimental reliance on the initial determination, expended substantial time and money on the application because: (a) the doctrine of equitable estoppel does not apply to state agencies acting in a governmental capacity; (b) the doctrine would be particularly inappropriate to apply to the Council because: (i) it has the duty of determining public need at the precise time and place and under the circumstances proposed, and (ii) the legislatively-declared crisis in the cost to state and local governments of medical services and the long-lasting economic harm caused by excess hospital construction necessitate unshackled freedom of governmental oversight; (4) the applicant and its counsel knew that the initial determination of need was conditional and that the doctrine of equitable estoppel probably did not apply to the state agency; and (5) to penalize the state agency because its representatives undertook to assist the applicant by providing the initial resolution proposing to approve would tend to discourage future aid by agency officials to applicants.

d. Fahey v. Public Health Council 453 N.Y.S.2d 824 (App. Div. 1982)

A person seeking to acquire and establish a nursing home brought an action appealing the Public Health Council's denial of its application. Under the state certificate of need/licensure statute such a facility may not be established without the approval of the Council. If the Council proposes to disapprove the application, it must offer the applicant the opportunity to request a public hearing which may be conducted by a Council-designated hearing officer. After proposing to deny and granting the applicant a hearing in this case, the Council denied the application notwithstanding the hearing officer's findings and conclusions recommending approval.

The applicant contended that the Council was required to adopt the findings and conclusions of its hearing officer unless the findings were not based on substantial evidence. The Court held that this argument was without merit because the Council, not the hearing officer, is authorized by the statute to determine the application. It is the Council's determination, not the hearing officer's report, which must be supported by substantial evidence.

e. University Community Hospital v. Tampa Heart Institute 445 So.2d 411 (Fla.Dist.Ct.App. 1984)

A hospital brought an action seeking judicial review of an administrative hearing officer's decision denying it leave to intervene in the administrative proceedings on its competitor's CON application. The Court denied relief, holding that the order of the hearing officer was merely a recommended order which could only be finally disposed of by the state agency involved.

16. Stare Decisions; Estoppel to Change Decision

a. Bayswater Health Related Facility v. New York State Department of Health 394 N.Y.S 2d 314 (App.Div. 1977), supra p. 139.

b. Hamptons Hospital and Medical Center v. Moore 417 N.E. 2d 533 (N.Y. 1981), supra p. 140.

c. Cf. Community Hospital of Los Gatos and Saratoga v. Office of Statewide Health Planning and Development 3 Civ. 19970 (Ca.Ct.App. 3rd Dist. Aug. 27, 1981)

A hospital brought an action seeking judicial review of a SHPDA decision denying its application for a certificate of exemption from CON for its project to reconstruct its emergency room. The state CON statute exempted projects undertaken "solely for the purpose of complying with requirements of law or regulations" and state regulations specified that "requirements of law or regulations" meant those with which the facility was under a legal duty to comply. State hospital licensing officials had inspected the facility, identified certain deficiencies which were not health and safety hazards, and stated in communications with the hospital that the state would require the hospital to institute corrective alterations or construction. However, the hospital was not actually under a legal duty to correct the deficiencies, because, first, the hospital was exempt from compliance under a grandfather clause in the licensure regulations, and second, the licensure agency's practice was not to require correction unless the deficiencies were a hazard to health and safety. The SHPDA denied the application on the grounds that the project was not actually required by law or regulation. The Court held that the hospital was entitled to a certificate of exemption, because it was led to believe by the hospital licensing agency, did believe, and acted on the belief that it was required by regulation and law to undertake alterations.

d. Carillo v. Axelrod 450 N.Y.S.2d 909 (App.Div. (1982))

A nursing home brought an action seeking judicial review of the decision of the Commissioner of Health (the final decision-maker on CON applications) refusing to approve its application for a CON to convert and expand its facility. In February 1979 the application was filed. In April 1979 the state agency advised the petitioner not to undertake expenditures for the conversion without various forms of official approval; in May 1979 it advised that the application was subject to final resolution of a pending hearing concerning revocation of the petitioner's underlying license. Subsequently, and before the license matter was resolved, the nursing home received a letter from a state agency architect approving the conversion plans and stating that "work may proceed at this time." The nursing home commenced work, expending $28.5K before the state notified it that the architect lacked authority to approve the project and that its application was still pending.

The Court held that: (1) the architect's letter did not constitute an approval of the application because under the CON statute the Commissioner's formal approval is required and the Commissioner may not be bound by an erroneous statement by his administrative employee architect; and (2) the state is not estopped to deny approval of the conversion because: (a) the doctrine of estoppel does not apply to the state acting in a governmental capacity, especially in the area of public health where governmental supervision is essential to protect consumers of public health care (citing Hamptons Hospital v. Moore; and (b) the record did not indicate that the nursing home's reliance on the architect's approval was reasonable, where the state agency advised it that approval was dependent on resolution of the licensure matter.

e. Westchester General Hospital v. Department of Health and Rehabilitative Services 419 So.2d 705 (Fla. Dist.Ct.App. 1982)

A hospital brought an action appealing a state agency decision that it had forfeited a grandfather exemption from CON for its replacement hospital construction project. The state legislature had amended the CON statute to provide that a statutory grandfather exemption provision would cease to be effective on July 1, 1979 and to require the state agency to notify all grandfather-exempt hospitals of their status by July 15, 1978. On Oct. 28, 1978 the agency gave the hospital its exemption notice, stating that to preserve the exemption after July 1, 1979 the project would have to be under "physical and continuous construction." During the first half of 1979 the hospital experienced difficulties in obtaining construction permits from the state agency and others and it did not obtain approval of construction plans from the state until Sept. 18, 1979. When the project had not proceeded beyond site preparation by Dec. 1979 the agency began forfeiture proceedings. In the proceedings the state took the position that activities beyond site preparation were necessary to comply with the "physical and continuous construction" requirement.

The Court held that although the hospital had failed to meet the requirements for preserving its exemption, the state agency was equitably estopped from revoking the exemption because: (1) the agency failed to meet its affirmative statutory duty to notify the hospital of its exemption by July 15, 1978; and (2) when it did provide notice on Oct. 28, 1978 it did not advise the hospital of its ultimate position of requiring construction beyond site preparation, and the hospital relied to its detriment on the agency's Oct. 28, 1978 position. The Court ordered the agency to determine on remand a reasonable time for the hospital to comply.

f. Schatzman v. Dept. of Health and Rehabilitative Services ("In re King Memorial Hospital II") 19 B.R. 885 (U.S. Bankruptcy Ct., S.D.Fla. 1982)

A trustee in bankruptcy brought an action seeking an order declaring it the possessor of a CON exemption for a project to construct a 126-bed hospital facility. The factual background of this case is described in the annotation to Schatzman v. Dept. of Health and Rehabilitative Services ("In re King Memorial I"), supra p. 41. The Court held that the King project met the state's requirements for obtaining and preserving a CON exemption.

The Court also held that DHRS was equitably estopped from acting to forfeit King's CON exemption either because King failed to commence the project prior to July 1, 1979 or because King did not undertake continuous construction thereafter. The action of DHRS working with and cooperating with King in approving the plans for construction five days prior to the July 1 deadline, together with King entering into a binding construction contract, met the requirements of equitable estoppel regarding commencement of the project. The estoppel argument was also valid with respect to continuous construction since once King commenced construction it would be unfair and unreasonable for DHRS to forfeit the exemption without affording King every reasonable opportunity to build.

17. Conditions on Approval

a. Authority to attach conditions on approval

(1) Zurbrugg Memorial Hospital v. Commissioner of Health No. A-931-74 (N.J.Super.Ct.App.Div. Nov. 13, 1975)

A hospital brought an action appealing the decision of the Commissioner granting it an equitable, non-statutory exemption from CON subject to the condition that the exemption was valid for only one year and would be forfeitable unless the hospital could demonstrate substantial progress on the project during that time. The Court upheld the authority of the Commissioner to grant an equitable exemption and held that where the Commissioner had that power he had the correlative power to impose conditions which were reasonable under the circumstances. This power is inherent in the Commissioner's function and is essential for him to perform his duty of approving or disapproving health facility construction. In addition, the Court held that the condition was not unreasonable or arbitrary, because: (1) the limitation imposed by the condition mirrored the time limitation on all certificates of need imposed by the CON statute; (2) to grant the exemption without a time limitation would frustrate the statutory scheme; and (3) the condition did not direct an unequivocal termination of the exemption after one year but instead simply placed the burden on the applicant to show substantial progress in order to continue thereafter.

(2) *Cf. National Nephrology Foundation v. Dougherty* 351 A.2d 392 (N.J.Super.App.Div. 1976)

A hospital brought actions appealing the denial of its application for a CON to establish a renal dialysis facility and the awarding of a CON to a competitor. There had been three competing applicants to satisfy the same need for renal dialysis. The Court's opinion noted, but did not discuss, a condition which had been attached to the approval of the successful application. The condition was compliance by the successful applicant with a contract it had entered into with the third (unsuccessful) applicant to cooperate in assuring full availability of renal dialysis to all physicians and patients in the area.

(3) *Pee Dee Regional Health Systems Agency, Inc. v. Dept. of Health and Environmental Control* No. 79-CP-40-3626 (S.C.Ct.C.P. May 13, 1981)

An HSA and others brought an action against the Department of Health and others seeking judicial review of a decision approving an application for a CON to construct a "long-term care rehabilitation facility" described as a unique facility providing both traditional nursing home services and extensive, specialized rehabilitative services. In granting the CON for the facility the state agency indicated that it would assure that the proposed facility would in fact provide unique, needed specialized rehabilitative services and not merely traditional nursing home services (for which no need was shown) by conditioning the facility's license on the performance of such specialized services. The Court concluded that the Board possessed the authority to attach such a condition to a licensure approval even in the absence of express statutory authorization. (*Compare Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission, supra*, holding that the state CON statute was not intended to be used as a tool to encourage hospitals to remedy licensing deficiencies.)

(4) Eagle Hill Corp. v. Commission on Hospitals and Health Care 477 A.2d 660 (Conn.App. 1984)

An alcoholism treatment hospital brought an action seeking judicial review of a Commission decision denying in part its April 1980 request for CON approval of a $705K cost overrun on its previously approved construction project. In 1976 the Commission had approved a $2.7 million capital expenditure to construct the facility. In January, 1979 it approved a $1.6 million overrun. From then till April, 1980 the hospital spent or committed itself to spend an additional $540K for various construction changes, and committed itself to an additional $165K capital expenditure to complete construction and additional financing costs, for a total of $705K. The Commission found that the hospital had inefficiently managed and monitored project costs and neglected to pursue its legal remedies against defaulting contractors or scale back project scope to hold costs to the previously-approved level. Consequently, it denied the $540K portion of the request. It approved the $165K portion with four conditions: (1) hospital submission of its annual operating and capital budgets upon the earlier of attainment of ninety percent occupancy or the end of the first year of operation; (2) annual submission of proposed budgets for six years; (3) hospital reporting of any estimated additional capital costs within one business day; and (4) a prohibition on additional changes in facility scope, cost, or services without the Commission's prior approval.

The state CON law provided in pertinent part: "Any health care facility...proposing a capital expenditure of one hundred thousand dollars or more...shall submit a request for approval of such expenditure...ninety days in advance of the proposed initiation date of such project." (Conn. Gen. Stats. §19-73m (Rev. to 1979)).

The Court upheld the first two conditions on the $165K approval because: (1) rooted in the Commission's statutory authority to "approve, modify, or deny" a CON application is the power to impose reasonable conditions; and (2) since the Commission had the statutory authority to annually demand submission of annual proposed operating and capital budgets upon 180 days notice, it was within its administrative power to require such submissions in advance with more than the required notice. The Court struck down the second two conditions because they lacked statutory or administrative justification and appeared to stretch administrative oversight into punishment.

b. Other Issues Regarding Conditions

(1) Temple Street Associations v. Commission on Hospitals and Health Care No. 101487 (Conn.Ct.C.P. New Haven County June 16, 1977)

A physician group brought an action seeking judicial review of a state agency decision denying their application for a CON to establish an ambulatory surgical center. The state agency denial contained the following statement:

> "In the denial, however, is the condition that, if within 120 days of the final Commission decision, none of the New Haven Hospitals have expanded their programs for ambulatory surgery, to include general anesthesia, at rates comparable to those proposed by the surgicenter's application, without hospital room costs, and which is acceptable to the staff surgeons and to this Commission; a reapplication of the free standing surgicenter would be welcome."

The state statute provided that the state agency must grant or deny applications within 90 days, and that failure to act within 90 days would be deemed an approval. The Court held that the state agency decision was an unauthorized deferral of action on the physicians' application for more than 90 days because the "conditional denial" in effect deferred action by giving the hospitals a 120-day period to fill an obvious void and otherwise finding the applicants qualified and "welcome." Therefore the Court held that the application had been deemed approved. (Cf. Greenburg v. Hospital of St. Raphael and Yale-New Haven Hospital, infra, which concerns the physician group's attempt to enjoin the hospitals from expanding their ambulatory surgery programs in accordance with the "conditional denial" without first obtaining CONs.)

(2) Bayswater Health Related Facility v. New York Dept. of Health 394 N.Y.S.2d 314 (App.Div. 1977)

A partnership brought an action seeking judicial review of a state agency recession of the agency's conditional approval of the partnership's application for a CON to establish a health-related facility. The state statute granted applicants whose projects the state agency proposed to disapprove the right to a public hearing. The state agency had conditionally approved the application and then, upon the alleged failure of the applicant to meet the condition, advised it that the application was withdrawn. The state agency refused to provide a hearing on the theory that the application had not been disapproved. The Court rejected this theory ruling that, since contingent approval had clearly been given, the state agency's only alternatives were to either approve the application or disapprove it and afford the applicant the opportunity to request a public hearing.

(3) Metropolitan Medical Center and Extended Care Facility v. Harris 693 F.2d 775 (8th Cir. 1982)

A hospital brought an action seeking judicial review of a DHHS decision denying Medicare reimbursement for: (1) the costs of free care incurred under its Hill-Burton uncompensated care obligation; and (2) the cost of certain community outreach programs which the hospital alleged it was required to provide under its Hill-Burton community services obligation.

Medicare pays the reasonable cost of services to Medicare patients, which includes necessary indirect costs. The hospital argued that costs required by Hill-Burton were necessary indirect costs of providing services to Medicare patients because they indirectly benefitted Medicare patients by qualifying the hospital for Hill-Burton assistance. The Court held that that the costs of Hill-Burton free care were not reimbursable indirect costs of providing services to Medicare patients because, among other things, although the free care was required by the Hill-Burton Act, Medicare reimbursement would be inconsistent with the purposes of Hill-Burton since the Act contemplated that hospitals would devote their own resources to satisfy its free care mandates. The Court also held that the costs of the community outreach programs were not costs required by the community service obligation of the Hill-Burton Act. Because they were not, valid or not the hospital's argument that costs required by Hill-Burton were reimbursable was inapposite.

The hospital argued for the first time on appeal that the community outreach programs had been required as a condition of obtaining a CON, and that they were therefore reimbursable necessary indirect costs of providing services to Medicare patients because they indirectly benefitted Medicare patients by qualifying the hospital for a CON required under state law before building new facilities. The Court ordered the case remanded to the PRRB for consideration of this argument, noting that Medicare reimbursement for such certificate of need costs would not be contrary to the state CON law in the manner that reimbursement for free care contravened the Hill-Burton Act.

(4) Faulkner Hospital Corporation v. Schweiker No. 82-1528 (1st Cir. Mar. 10, 1983), affg., 537 F.Supp. 1058 (D. Mass. 1982)

A hospital brought an action seeking judicial review of a PRRB decision denying Medicare reimbursement for certain costs which were associated with its compliance with a condition attached to the hospital's CON to replace and expand its facility. The hospital had been granted a CON for replacement, with expanded bed capacity at the replacement facility authorized on the condition that it acquire another nearby hospital, operate it for a time, and close it down before opening the new facility, in order to accomplish a net reduction in total area bed supply.

The acquired hospital incurred operating deficits during its phasedown period. Faulkner advanced $1.25M to the acquired hospital to cover the deficits and added that sum to the cost basis of the new facility on which it sought a Medicare depreciation allowance.

Medicare reimbursement principles provided for reimbursement for the reasonable cost of services including all necessary and proper costs, defined as costs "which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurences in the field of the provider's activity." (42 C.F.R. §405.451(b)). The PRRB concluded that the hospital's advances to the acquired facility were not necessary and proper because: (1) the expansion itself was unnecessary since it was not compelled but merely conditioned in the CON; and (2) the submitted costs were unrelated to patient care in the new facility, being instead an attempt to obtain double reimbursement for care provided in the acquired facility. The District Court held that the extraordinary losses incurred by the acquired hospital, which were directly attributable to constraints imposed on its operation by Faulkner's CON, were reimbursable necessary and proper indirect costs of providing care to Medicare patients in Faulkner's new facility.

The Court of Appeals affirmed, holding that: (1) the fact that the CON was conditional did not mean that Faulkner manufactured the need for expansion by acquiring the second hospital but rather that the SHPDA had identified a need to replace the acquired hospital, and Faulkner fulfilled this need. (2) Faulkner was entitled only to reimbursement for those advances made to the acquired hospital which related to costs actually caused by the state-mandated phase-out (such as the extraordinary overhead cost of maintaining a hospital over a a three-year period during which its medical staff and patient population were dwindling) and, although the determination of these amounts on remand would raise difficult accounting questions, Faulkner would not receive double reimbursement for the routine costs of providing care to Medicare beneficiaries at the acquired hospital.

18. Time Periods for Review

a. Section 1122 Cases

(1) *Lakeside Mercy Hospital v. Indiana State Board of Health* 421 F.Supp. 193 (N.D.Ind. 1976), *aff'd mem.*, 547 F.2d 1170 (7th Cir. 1976)

A corporation formed to establish a hospital brought an action seeking a declaratory judgment that its application for reimbursement under Section 1122 of a project to construct a new facility should be "deemed approved." Because it had been enjoined from acting on applicant's proposal (in a lawsuit not otherwise relevant to this discussion), the DPA had failed to provide notification of its rejection of the application within the time period specified in federal 1122 regulations. Federal regulations provided that failure to provide timely notification of rejection was deemed to be an approval (42 CFR 100.106(a)(4)). The Court held that the otherwise absolute deadline in the federal regulations should be construed to include by inference a tolling provision applying whenever, as in this case, the DPA was subject to jurisdictionally appropriate, court-ordered restraint. *Compare* *Pratt v. Board of County Commissioners*, *supra*.

(2) *Nebraska Methodist Hospital v. Casari* No. CV77-L-256 (D.Neb. Aug. 18, 1978); [1978 Transfer Binder] *Medicare and Medicaid Guide* ¶29,205.

A hospital brought an action seeking injunctive relief and a declaratory judgment that its application for reimbursement under Section 1122 of a project to construct a new hospital be "deemed approved." The DPA had made findings recommending denial of reimbursement. The DPA had received the application on July 16, 1976, and on July 28, 1976, had sent the applicant a notification of incompleteness requesting additional information. On Aug. 13, 1976, the applicant supplied information requested in the July 28 notice. The DPA requested additional information several other times. The DPA finally notified the applicant of its disapproval of the project on Dec. 23, 1976.

When an 1122 application is incomplete, the federal 1122 regulations (42 CFR §100.106(a)(3), (4)) (1) require the DPA to send a notification of incompleteness within 15 days of receipt of the application, (2) require the DPA to notify applicant of its disapproval of the application 90 days after receipt of the additional information requested in the notification of incompleteness, and (3) provide that failure to provide timely notification of disapproval is deemed an approval (42 CFR §100.106(a)(4)).

The applicant argued that the DPA could send only one notification of incompleteness and that after receipt of a response it had to deny the application within 90 days or else it would be deemed approved. The DPA argued that it should be permitted to send an indefinite number of notifications of incompleteness as long as each was within 15 days of receipt of the response to the preceding notification. The Court held for applicant concluding that the most reasonable interpretation of the regulations was that there is only one 15-day period in which the DPA may point to areas of incompleteness. The Court held that the plaintiff's application was therefore deemed approved.

(3) *Samson v. Bureau of Community Medical Facilities Planning* 363 So.2d 412 (Fla.App. 1978)

A hospital brought an action seeking judicial review of a DPA decision recommending denial of reimbursement under Section 1122 of its project to construct a new facility. The application was deemed complete on December 2, 1975. During the review period the applicant agreed to a sixty-day extension of the time period for review. The DPA did not deny the application until May 11, 1976, more than 150 days after the application was deemed complete. The Section 1122 regulations require the DPA to notify the applicant of its disapproval of the application 90 days after the application is filed and provide that failure to give timely notification is deemed an approval. The Court held that as a consequence of the failure to provide timely notification of disapproval the hospital's application was deemed approved.

(4) *Sisters of St. Mary v. Percy* No. 79-CV3785 (Wisc.Cir. Ct. Dane County Sept. 26, 1979)

A hospital brought an action seeking to have its application for reimbursement under Section 1122 of a project to acquire a CT scanner deemed approved. The DPA had issued a negative recommendation on Sept. 18, 1978. The hospital's request for a fair hearing was received by the DPA on Sept. 25, 1978. No hearing was commenced within thirty days thereafter. The federal 1122 regulations provide that following a negative recommendation an applicant may request a fair hearing which "shall be commenced within 30 days after receipt of the request." (42 CFR §100.106(c)(2)). The federal 1122 regulations also provide that applications are "deemed approved" if the DPA fails to take certain actions within specified time limits, such as rendering a final decision within 45 days after the conclusion of the fair hearing, (*see*, *e.g.*, 42 CFR §100.106(a)(4), (c)(3), (5)), but does not set forth any adverse consequences for failure to provide a fair hearing within 30 days after the request. The Court held that the 30-day time limit for commencing a fair hearing was mandatory, not directory, because: (1) logic dictates that the legislature intended it to be mandatory since it would be anomalous to permit the DPA to delay indefinitely the commencement of the fair hearing while requiring a decision within a fixed time after the hearing's conclusion, and (2) the clear implication of a provision of Section 100.106(c)(2) which gives the applicant the right to request an extension of the 30-day period is that the DPA has no right to extend the time period on its own. [*Compare* *Benedictine Sisters Benevolent Association v. Pettersen*, *infra*.]

(5) Nazareth Literary and Benevolent Institution, Inc. v. W. Grady Stumbo No. C-81-0637 L(A) (W.D.Ky. Dec. 4, 1981)

A hospital brought an action seeking to enjoin submission to DHHS of a DPA decision, affirmed by a designated hearing officer, recommending denial of reimbursement under Section 1122 of its project to construct a new long-term care facility. The 1122 regulations require that the hearing officer notify the person requesting the hearing of his decision not more than 45 days after the conclusion of the hearing, with an untimely notification deemed an approval. (45 C.F.R. §100.106(c)(3)). The petitioner's hearing concluded on August 25, 1981. The mailed decision was postmarked October 13, 1981 and received by petitioner's attorney on October 14, 1981, 50 days after the hearing ended. The 1122 regulations also require a DPA to establish and maintain 1122 notification and review procedures (42 C.F.R. §100.106). The DPA had not done so.

The Court enjoined the negative recommendation, holding that the timely notification rule requires actual delivery of the hearing officer's decision to the hearing requestor, not just mailing of the decision or placing a copy of the decision in official mailing channels, within 45 days after the hearing. [In 47 Fed. Reg. 7230 (Feb. 18, 1982) DHHS announced a new interpretive ruling providing that notice under the three required notice provisions of the 1122 regulations will be effective on the date the DPA or hearing officer mails to the applicant its finding. The three required notices are: (1) DPA notification to an applicant that additional information is required (42 C.F.R. §100.106(a)(3); (2) DPA notification to the applicant as to whether the project is consistent with applicable criteria, etc. (42 C.F.R. §100.106(a)(4); and hearing officer notification of his decision to the applicant (42 C.F.R. §100.106(c)(3). This interpretive ruling applies by its own terms only to each initial determination by the Secretary made after Feb. 18, 1982. -- ED.]

The Court also observed that the failure of the DPA to officially promulgate 1122 review regulations deprived it of authority to act, citing Nebraska Methodist, but declined to base its decision on that ground because to do so could conceivable jeopardize the entire state 1122 program.

b. CON Cases

(1) Humana of Florida, Inc. v. Keller 329 So.2d 420 (Fla.Dist.Ct.App. 1976)

A hospital brought an action seeking declaratory and injunctive relief alleging that the state agency erred in failing to provide a public hearing on the application of its competitor to construct a new hospital before the agency issued a CON to the competitor. The state CON statute required an areawide planning council to conduct a public hearing or, if there were no areawide planning council, required the state Bureau of Community Medical Facilities Planning (BCMF, the final CON decision-maker) to request the state Bureau of Comprehensive Health Planning to process the application and provide the prescribed public hearing. The areawide council was required to submit advisory recommendations to BCMF, which made the final decision on the application. The statute also provided that if the areawide council failed to make a decision within 90 days of filing of the application, the application was deemed approved by the council.

In this case there was no areawide council, and no hearing was held before the application was approved. The Court held that a hearing should have been held (rejecting the state agency's arguments that the public hearing procedure was not mandatory and that, in the absence of a hearing, the expiration of 90 days from the filing of the application operated as an approval of the application) because the statutory requirement for notice and hearing cannot be mooted by bureau delay or evasion.

(2) Benedictine Sisters Benevolent Association v. Pettersen 299 N.W.2d 738 (Minn. 1980)

A hospital brought an action seeking a order that its application for a CON to establish a cardiac surgery program be "deemed approved." State law provided that the SHPDA shall make its decision on a CON application within 30 days after receiving the HSA recommendation. The SHPDA failed to meet the 30-day deadline, denying the application after 60 days. The hospital argued that the deadline was mandatory and that it was therefore entitled to an approval. The Court held that petitioner was not entitled to a CON because the deadline was only directory, being designed merely to assure uniform, prompt review, and because, given the legislative intent to prevent unnecessary projects, the time limit should not be interpreted to preclude the SHPDA from exercising its discretion to deny a CON application. [Compare Sisters of St. Mary v. Percy, supra.]

(3) Bradbury Memorial Nursing Home v. Tall Pines Manor Associates 485 A.2d 634 (Me. 1984)

A nursing home (Bradbury) brought an action seeking judicial review of the issuance of a CON to its competitor (TP) for new nursing home construction. The state CON statute and regulations provided that the time period for review under a comparative review cycle could extend 150 days. The state agency calculated that the review cycle beginning October 15, 1982 would expire March 13, 1983. The state agency's

Procedures Manual contained a provision not formally adopted as a regulation stating that the agency's failure to notify a CON applicant of its decision within the agency's deadline would have the effect of a decision to deny the CON.

TP, BMA (an association proposing to purchase Bradbury), and a third competitor (Northpoint) filed competing CON applications within the October 15, 1982 review cycle proposing to construct new nursing home facilities to satisfy a state-identified need. The HSA recommended approval of the BMA application, but BMA withdrew its application March 4, 1983. On April 4, 1983, after the review cycle expiration date, the state agency approved the TP application and denied Northpoint's application. Bradbury unsuccessfully sought an administrative reconsideration and then brought this action.

The Court upheld the state agency approval of TP, holding, among other things, that the TP application was not automatically denied upon expiration of the 150-day review period by operation of the above-noted provision of the Procedures Manual because: (1) The meaning of the provision was to place an applicant who had not received notice of a decision in a position to petition the state agency for reconsideration -- the same position as a party whose application had been expressly denied. (2) The statutory 150-day time period for review was directory, not mandatory or jurisdictional. The time periods in the CON statute served the hortatory purpose of curbing bureaucratic delay and giving an applicant a legal basis for obtaining a judicial order compelling a decision. They did not mean that it was absolutely essential that the specified action take place within the set time period. [*Compare Benedictine Sisters Benevolent Association v. Pettersen*, *supra*.] (3) If the Procedures Manual provision were interpreted to provide for automatic denial or "pocket veto" it would violate the state statutory requirements for findings to accompany CON decisions and detailed statements of reasons for decisions inconsistent with HSA recommendations, and underlying common law findings requirements. (4) If the Procedures Manual were interpreted to provide for automatic denial or "pocket veto" it would contravene federal CON regulations which provide that a CON may not be denied solely because the state agency fails to reach a decision. 42 C.F.R. §123.410(a)(17) (1983). The Manual provision should not be interpreted to do so, because the state CON statute declared the federal regulations binding upon the state by providing that an express purpose of the statute was to provide for a CON program meeting the requirements of NHPRDA and its accompanying regulations. (5) Interpreting the Procedures Manual provision not to require automatic denial is consistent with the overall purpose of the state CON statute to identify and satisfy as promptly as possible the need for additional health care services.

(4) Lahey Clinic Hospital, Inc. v. Dept. of Public Health No. 83-1019 (Mass. Super. Ct., Middlesex Cty. March 18, 1983)

A hospital brought an action in mandamus seeking a court order directing the state agency to review its application for a CON. The state CON statute required the agency to approve or disapprove a CON application within 8 months after filing, with one 2 month extension after the applicant provided additional information at agency request. The statute also authorized an applicant to sue within a reasonable period of time to compel state agency action if the agency had not acted within the time periods for review. The hospital filed its application on January 4, 1982. The state agency did not act on the application by Sept. 4, 1982, although it commenced application processing in November 1982. The hospital brought this action on February 23, 1983. The Court granted the hospital's petition, holding that the action was brought within a reasonable period of time after the expiration of the 8 month period. The Court ordered the state agency to approve or disapprove the application within 6 weeks.

19. Special Issues Concerning Administrative Appeals

a. Jurisdictional Issues

(1) Availability of relief by way of administrative appeal

(A) Bio-Medical Applications of Ocala, Inc. v. Department of Health and Rehabilitative Services 374 So.2d 88 (Fla.Dist.Ct.App. 1979)

Bio-Medical Applications (BMA), a renal dialysis facility whose CON application had been denied, brought an action appealing the state agency's denial of its request for a hearing on the approval of a competitor's application for a CON to construct a renal dialysis facility in the same area. The Court held that the state agency should have granted the request for a hearing because: (1) the state had acknowledged that the applications were mutually exclusive by simultaneously denying BMA's and granting the other, and by giving as the basis for denial that the competitor's application was comparatively better; and (2) where simultaneously-filed applications are mutually exclusive each competitor is potentially a party to the proceedings on the other's application and has the right to request a hearing in those proceedings.

(B) Hollingsworth v. Schweiker 664 F.2d 526 (5th Cir. 1981), connected case sub. nom. Hollingsworth v. Harris 608 F.2d 1026 (5th Cir. 1981)

A nursing home brought an action seeking judicial review of the Secretary of HHS's approval for reimbursement under Section 1122 of its competitor's project to construct a nursing home. In the course of ruling on the scope of HHS review of the DPA's decision, the Court observed in dicta that Section 1122 only requires that the proponent of a facility be given the right to administratively appeal the DPA's initial determination because Congressional intent in adopting Section 1122 was to accommodate two divergent goals (not funding unnecessary health facilities and employing a streamlined review procedure that would avoid delaying needed construction) by granting protection to the proponents of health facilities which it denied others. In other words, to streamline the procedure Congress chose to err on the side of overfunding. If the state agency erroneously determined that a facility should be reimbursed for its capital expenditures, an opponent of that facility would be unable to request a state hearing officer to review the DPA's recision.

(C) Cf. University Park Convalescent Center v. Aetna Life and Casualty Co., PRRB Hearing Dec. No. 81-D1R (Dec. 9, 1982), CCH MEDICARE & MEDICAID GUIDE ¶31,693.

A nursing home brought an administrative appeal before the PRRB of a Medicare fiscal intermediary's exclusion of reimbursement, pursuant to a negative 1122 determination, of costs associated with a capital expenditure. The PRRB dismissed the appeal, ruling that Section 1122(f)'s bar on administrative and judicial review of the Secretary's decision precluded its review of the propriety of a penalty assessed a provider by a fiscal intermediary pursuant to a negative 1122 determination. This decision was reached by the PRRB on remand from HCFA Acting Deputy Administrator Decision (Mar. 8, 1981), CCH, MEDICARE AND MEDICAID GUIDE ¶30,993, vacating and remanding PRRB Hearing Dec. No. 81-D1 (Jan. 8, 1981), CCH MEDICARE & MEDICAID GUIDE ¶30,883 in which the HCFA Administrator cited an HHS Office of General Counsel opinion that the jurisdiction of the PRRB in reviewing the propriety of an intermediary's adjustment reflecting a negative determination under Section 1122 was limited to reviewing the mathematical calculations involved in determining a Section 1122 exclusion. See also PRRB Hearing Dec. No. 77-D59, (Sept. 1, 1977) CCH, MEDICARE AND MEDICAID GUIDE ¶28,647 in which the PRRB ruled that it did not have authority to consider issues relating to the propriety of the DPA negative recommendation on a capital expenditure.

(D) Cf. Humana Medical Corporation v. Schweiker No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. The hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc. As one of several preliminary rulings on jurisdictional issues, the Court held that it did not have jurisdiction to review the Secretary's 1122 determinations by way of its jurisdiction to review PRRB decisions because 1122(f) barred PRRB review of the Secretary's determinations.

(E) Loyd v. Georgia State Health Planning and Development Agency 310 S.E.2d 738 (Ga. App. 1983)

Several area residents brought an action seeking judicial review of the decision of the State Health Planning Review Board (SHPRD), an administrative appellate body, that they were not entitled to obtain administrative review by the SHPRD of the issuance by the SHPDA of a CON. The trial court had ruled that their petition for judicial review was fatally defective because it failed to name the SHPRD as a party respondent, necessary because the SHPRD was the body which made the decision by which the petitioners were allegedly aggrieved. At the time the trial court reached its decision the state CON statute granted the right to obtain SHPRD administrative review to any person who qualified as a "party" or "person aggrieved" under the state APA. While the area residents' appeal of the trial court decision was pending before the Court of Appeals, the CON statute was amended to limit the right to SHPRD administrative review to applicants, competitors, and local governments.

The Court of Appeals first held that although the SHPRD was an independent, separate entity from the SHPDA whose decisions superseded those of the SHPDA and were judicially reviewable at the request of the SHPDA, the SHPDA was the proper party respondent to the petition for judicial review, not the SHPRD, because the SHPRD was a quasi-judicial appellate body whose function was solely adjudicatory, having no stake in the outcome of the litigation nor duty or interest in defending its decision on appeal. Thus, the petition was not defective for failure to name the SHPRD as an indispensable party. The Court then ruled that the area residents were not entitled to SHPRD administrative review because: (1) Since no vested rights were involved, the Court was required to decide their claim under the law as it existed at the time of its judgement, rather than the law prevailing at the rendition of the judgement under review; and (2) under the amended law, the area residents lacked the right to administrative review.

(2) Standing to obtain administrative appeal

(A) Extendicare, Inc. v. State Coordinating Council for Health Planning 532 P.2d 1119 (Kan. 1975)

An out-of-state corporation, an individual physician, and a professional physicians' corporation brought an action appealing the decision of the Coordinating Council (the 314(b) agency and final decision-maker on CON applications) denying them standing to appeal to the Council the decision of the local 314(a) agency granting a CON to their competitor to expand its facility. The out-of-state corporation held a CON to construct a hospital in the state but no operating license. The physician and the professional corporation were licensed in the state. The CON statute granted standing to appeal 314(a) decisions to applicants and to "health facilities," defined elsewhere in the CON statute as "any health or medical facility that is licensed" by the state. The Court held that: (1) the out-of-state corporation was not a health facility because it lacked a license; therefore it lacked standing to appeal; and (2) the physician and professional corporation lacked standing because, viewing the CON statute in its entirety, it was apparent that the legislature did not intend to embrace them within the term "health facility."

(B) Suburban Medical Center v. Olathe Community Hospital 597 P.2d 654 (Kan. 1979)

A hospital brought an action appealing the granting of a CON by the SHCC (the final CON decision-maker in the state) to a competitor to expand its facility. The state agency had initially denied the application, whereupon the applicant had requested a hearing before the SHCC. The plaintiff hospital sought, and was granted, leave to appear as a party at that hearing. The state CON statute granted party status to "adversely affected" facilities. In this litigation the applicant argued that the SHCC had erred in granting the hospital party status since it was, in essence, the winner under the initial state agency decision and therefore not "adversely affected." The Court disagreed, holding that, as a subsequent amendment to the statute had made explicit, the term "adversely affected facilities" included facilities which would be potentially adversely affected by the final decision on the application.

(C) Cf. In re Wilkesboro, Limited 285 S.E.2d 626 (N.C.Ct.App. 1982), cert. den. 290 S.E.2d 365 (N.C. 1982)

A skilled nursing facility brought an action seeking judicial review of a state agency denial of its request for a hearing to reconsider the state agency's decision that the SNF construction project of its competitor (Wilkesboro), located in the same county and less than two miles from petitioner, was exempt from CON under a statutory grandfather clause. The state agency's decision consisted of a letter informing Wilkesboro that it could continue construction without meeting the requirements of the CON law.

The state agency had denied the petitioner's request on the grounds that under the state's CON regulations a reconsideration hearing was available only to "persons aggrieved", and petitioner was not within that category. The state CON statute required that the state agency comply with the state APA and give persons qualifying as "persons aggrieved" under the APA the administrative appeal and judicial review rights provided under that Act. The state APA provided that "Any person who is aggrieved by a final agency decision in a contested case, and who has exhausted all administrative remedies made available to him by statute or agency rule, is entitled to judicial review...." The state APA also defined persons aggrieved as persons "directly or indirectly affected substantially in their person, property, or public office or employment by an agency decision" and the CON regulations defined "persons aggrieved" in identical terms. Finally, the APA defined a "contested case" as an agency proceeding wherein the legal rights, duties or privileges of a party are required by law to be determined by an agency after opportunity for an adjudicatory hearing.

The Court of Appeals ruled first that the petitioner had standing under the state APA to seek judicial review of the state agency's decision exempting its competitor from CON because: (1) the matter was a "contested case" because, although there was no adjudicatory hearing, the state agency knew there was a question whether Wilkesboro was entitled to an exemption and it had a duty to determine that question; (2) as evidenced by the state agency's letter to Wilkesboro and its letter to petitioner denying reconsideration the state agency had reached a "final agency decision" on the case; and (3) petitioner was a "person aggrieved" because as a prospective competitor it had a substantial stake in the outcome of the controversy that would cause it to seek complete review and full adjudication of the issue. The Court then remanded the case to the state agency to conduct a reconsideration hearing, apparently concluding that the requirements for standing to seek reconsideration as a "person aggrieved" were the same as the requirements for standing under the APA to seek judicial review.

(3) Consolidation, intervention, etc., in administrative appeal proceedings

(a) See also cases annotated at Section III.A.8. "Consolidation, Intervention, Etc., in Administrative Review Proceedings" and Section IV.A.2.C.

"Consolidation, Intervention, Etc., in Judicial Review Proceedings."

(B) Bio-Medical Applications of Clearwater v. Department of Health and Rehabilitative Services 370 So.2d 19 (Fla.Dist.Ct.App. 1979)

Bio-Medical Applications (BMA), a kidney dialysis center which had been denied a CON and a Section 1122 approval of its project to construct a 20-station dialysis center in the city of Clearwater, brought an action appealing the awarding of a CON for a dialysis center in the city of Clearwater to Kidneycare, its competitor. BMA sought a court order compelling the state agency to rehear the two applications in a comparative, consolidated proceeding.

The relevant proceedings began when the state agency initially disapproved Kidneycare's application, after which Kidneycare requested a hearing. BMA, whose application had by that time also been disapproved, and whose own hearing was pending, was permitted to intervene and participate in Kidneycare's hearing. However, its motion for consolidation of the two hearings was denied. Kidneycare's application was then fully approved at its hearing. Later, Bio-Medical's hearing resulted in an approval of only seven of its requested 20 stations.

The Court held that the state should have held a consolidated, comparative hearing on the two applications. (1) Whenever an applicant is able to show that the granting of authority to some other applicant will substantially prejudice his application, fairness requires that the agency conduct a comparative hearing in which the competing applications are considered simultaneously. Permitting an applicant to intervene and participate in the hearing on the competing application is insufficient since the merits of the intervenor's proposal are not thereby presented for comparative consideration. (2) In this case the applications were clearly competing, because they both proposed to satisfy an areawide need determined in accordance with a quantitative standard that had the effect of creating a fixed pool of needed investments. The granting of one application for a number of units automatically decreased need and effectively denied the other application to the extent of that number of units. (3) Comparative reviews of competing applications are required for fairness to applicants, are not unduly burdensome to the state agency (which should adopt a mechanism for determining when a comparative hearing is required), and advance the public interest by permitting comparative analysis of the cost effectiveness of projects. [The Court thus adopted for CON and 1122 review purposes the doctrine announced in Ashbacker Radio Corp. v. FCC 326 U.S. 327 (1945) in which the Supreme Court held that where two bona fide applications for administrative approval are mutually exclusive, the grant of one without a hearing to both deprives the loser of the hearing to which he is entitled-Ed.]

(C) Cf. Bio-Medical Applications of Ocala, Inc. v. Dept. of Health and Rehabilitative Services 374 So.2d 88 (Fla.Dist.Ct.App. 1979)

Bio-Medical Applications (BMA), a renal dialysis facility whose CON application had been denied, brought an action appealing the state agency's denial of its request for a hearing on the approval of a competitor's application for a CON to construct a renal dialysis facility in the same area. The Court held that the state agency should have granted the request for a hearing because: (1) the state had acknowledged that the applications were mutually exclusive by simultaneously denying BMA's and granting the other, and by giving as the basis for denial that the competitor's application was comparatively better; and (2) where simultaneous applications are mutually exclusive each competitor is potentially a party to the proceedings on the other's application and has the right to request a hearing in those proceedings.

(D) South Broward Hospital District v. Department of Health and Rehabilitative Services 385 So.2d 1094 (Fla.Dist. Ct.App. 1980)

South Broward Hospital, which had been awarded a CON to acquire a CT scanner, brought an action for a writ of prohibition or review seeking an order that Hollywood Medical Center, which had earlier been denied a CON to acquire a CT scanner, was not entitled to seek an administrative appeal of the award of the CON to South Broward. Hollywood's application was denied for lack of need in the area; 18 days later South Broward's application to serve the same area was approved pursuant to an "extenuating circumstances" criterion which permitted modification of the criteria relating to need. The state agreed to Hollywood's request that it hold a consolidated hearing to review Hollywood's denial and South Broward's award notwithstanding a state regulation which provided that an applicant did not have standing to request an administrative hearing on the issuance of a CON to another applicant. The Court refused to prohibit the consolidated hearing, holding that: (1) despite the regulation Hollywood would be entitled to request the consolidated hearing if its application and that of South Broward were mutually exclusive, i.e., proposing to satisfy the same need; and (2) the Court would not interfere at this point with the state agency's determination of whether the applications were mutually exclusive because the determination involved the resolution of questions of fact and because, that being the case, South Broward had not yet exhausted its administrative remedy of contesting Hollywood's standing at the administrative hearing.

(E) Collier Medical Center, Inc. v. Dept. of Health and Rehabilitatiave Services 462 So.2d 83 (Fla.Dist.Ct.App. 1985)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a certificate of need to construct a new hospital which would serve two counties. Three existing competitor hospitals in the two counties, one of which also operated a "primary care center emergency room" in the area and the other two of which had large charity case loads, had been permitted to intervene in the hospital's administrative hearing as persons whose "substantial interests" were affected by the proposed agency action. The Court uphold the agency decision. It held, among other things, that the competitors were entitled to intervene in the hospital's administrative hearing because the effect of the proposed facility on their continued financial feasibility constituted a "substantial interest."

(F) Federal Property Management Corp. v. Health Care and Retirement Corp. of America 462 So.2d 493 (Fla.Dist.Ct.App. 1984)

A nursing home (FPMC) brought an action seeking judicial review of a CON administrative appeals hearing officer's decision denying it leave to intervene in another nursing home's (HCRCA's) administrative appeal of a state agency denial of its CON application.

Both FPMC and HCRCA had filed nursing home construction applications in the June - August 1982 batch cycle, been denied, and filed consolidated administrative appeals. HCRCA had also filed an apparently identical application in a succeeding batch cycle, been denied, and administratively appealed. A series of continuances were granted in both sets of appeals. Eventually the hearing on the second HCRCA application was set for a date before the hearing on the earlier, consolidated applications. FPMC sought intervention in the hearing on the second HCRCA application and consolidation of that case with the proceedings on the earlier applications. The Court reversed the hearing officer's denial of intervention and granted FPMC leave to intervene because: (1) relying on the "Ashbacker" doctrine, the state's courts had previously held that where CON applications were mutually exclusive the state agency was required to conduct a comparative hearing at which the applications were considered simultaneously; and (2) applicants from earlier batching cycles should be entitled to intervene in proceedings to dispose of later-batched, competing applications, where the hearing on the later-batched applications would be held prior to the hearing on the earlier-batched applications, since to hold otherwise would allow circumvention of Ashbacker.

(4) Other jurisdictional issues

(A) Memorial Hospital of Southern California v. State Health Planning Council 28 Cal.App. 3d 167, 104 Cal.Rptr. 492 (1972)

Several competitor hospitals brought an action to compel the SHPC (the final decision-maker on CON applications) to conduct a hearing on an appeal of a decision by an area health planning agency concerning their competitor's application to convert its facilities from convalescent to acute care. The appeal had been brought by one-third of the members of the governing body of the area agency, as they were permitted to do by statute, but upon withdrawal of several of the governing body members from the appeal the SHPC had dismissed it. The Court held that: (1) the competitor hospitals had standing to bring the action, and (2) the SHPC erred in dismissing the appeal because the members signing the appeal did not have the authority to withdraw since to do so would frustrate the interests of the remaining signatories and since permitting such appeals to be so readily abandoned would contradict the legislature's determination that such appeals were in the public interest.

(B) Cf. Olathe Community Hospital v. Kansas Corporation Commission 652 P.2d 726 (Kan. 1982)

A hospital which had been granted a CON brought an action seeking a judicial determination whether its competitor's appeal of the CON should be lodged in an administrative appeals board (KCC) or in a trial court. Effective July 1, 1982 the state CON statute was amended to repeal the requirement that SHPDA decisions be administratively reviewed by the KCC before judicial review would be permitted (with the request for administrative review filed within 30 days after the SHPDA decision) and to permit direct appeal to court with a similar 30-day period. On June 18, 1982 petitioner received its CON and on July 14 and 16 respectively the competitor filed notices of appeal in both KCC and the local trial court. The Court held that the administrative appeal in the KCC should be dismissed and the appeal heard in the trial court because statutory procedural changes may be applied to pending disputes and administrative appeals are not a matter of right.

b. Qualifications of Appeals Panel Members

(1) Olathe Hospital Foundation v. Extendicare, Inc. 539 P.2d 1 (Kan 1975)

Several hospitals brought an action seeking judicial review of a state agency appeals panel's final decision granting a CON to their competitor to construct a new hospital. The hospitals argued that the decision was invalid because of various defects in the composition of the appeals panel, the qualifications of panel members, and the failure of panel members to swear an oath of office and file conflict of interest disclosure statements. The Court held that by their failure to object to the composition of the panel at the time of the hearing before the panel the hospitals forfeited the right to complain because the panel members were de facto officials, i.e., persons who assume their official duties under color of authority, perform their duties, and are recognized and accepted as public officers by all who deal with them.

c. Issues Relating to the Involvement of Government Agencies With Differing Interests at Appeals Hearings.

(1) St. Vincent's Hospital v. Finley 380 A.2d 1158 (N.J. Super.App.Div. 1977)

A hospital brought an action seeking judicial review of a state agency appeals board's decision denying its application for a CON to construct a replacement facility. An initial recommendation on the hospital's application had been made by the CHP "b" agency followed by another recommendation by the Commissioner of Health. Both the Executive Director of the "b" agency and the Commissioner of Health were members of the Health Care Appeals Board which made the final decision on CON applications. The hospital alleged that it had been deprived of a fair hearing because both the Commissioner and the "b" agency director were permitted to make presentations to the HCAB while its representatives were precluded from doing so. The Court held that in this unusual administrative setting where the Commissioner, whose recommendation was the subject of the hearing, was herself a member of the reviewing body, fairness in fact and appearance required that on remand from the Court to the HCAB the Board permit the applicant to respond appropriately to any statement made by the Commissioner in support of her recommendation.

(2) State Health Planning and Coordinating Council v. Hyland 391 A.2d 1247 (N.J.Super.Ct.App.Div. 1978)

A SHCC brought an action against the state Attorney-General seeking judicial review of the AG's decision refusing to represent the SHCC in a "fair hearing" in the course of a CON review. Initial decisions on CON applications were made by the Commissioner of Health with the SHCC having the opportunity to make a recommendation to the Commissioner and the SHCC and the applicant having the right to seek a "fair hearing" following the Commissioner's decision. The "fair hearing" was held before a hearing officer of Health Care Administration Board.

In this case the "fair hearing" was convened to consider two competing applications, one of which the Commissioner had favored and the other of which the SHCC supported. The AG refused to represent the SHCC directly at the hearing because his office already represented the Commissioner, and refused to appoint special counsel to represent the SHCC because the applicant which the SHCC supported was already adequately represented at the hearing by its own counsel and SHCC members would have the right to appear, testify, and submit written comments at the hearing. The Court held that the AG did not abuse his discretionary authority in refusing to represent or appoint Special Counsel for the SHCC.

(3) In re Behavioral Science Institute 436 A.2d 1329 (N.H. 1981)

An institute proposing to construct a new psychiatric hospital brought an action appealing the denial of its CON application. The state agency had initially approved the application. The HSA and a competitor requested a reconsideration hearing. The state CON statute provided for the establishment of a state health planning agency with a director and staff under the state Commissioner of Health and Welfare. The state statute did not specify who conducted the reconsideration hearing, but it did provide that following the hearing the "state agency shall make written findings which state the basis for its decision." The Commissioner appointed himself hearing officer at the reconsideration hearing and apparently made the decision denying the application. The Court reversed, holding that the Commissioner lacked authority to conduct the reconsideration hearing because the purpose of the hearing was for the state agency to consider once again the grounds for its determination, not for the Commissioner to substitute his decision for that of the state agency.

d. Promulgation of Rules Governing Administrative Appeals of Section 1122 Decisions

(1) Nebraska Methodist Hospital v. Casari No. CV77-L-256 (D.Neb. Aug. 18, 1978); [1978 Transfer Binder] Medicare and Medicaid Guide ¶29,205.

A hospital brought an action seeking declaratory and injunctive relief that its application for reimbursement under Section 1122 of a project to construct a new hospital be "deemed approved". At the time the hospital's application was recommended for denial of reimbursement the DPA had not formally promulgated regulations establishing procedures pursuant to which 1122 applicants could file notices of intent to make capital expenditures, appeal negative recommendations, and obtain fair hearings. The hospital did in fact appeal and was granted a hearing in this case.

The Section 1122 statute provides that the Secretary of HHS shall enter into agreements with states under which state DPA's will "establish and maintain" appeal procedures. (42 U.S.C.A. §1320(b)(3)). The Section 1122 regulations provide that the Agreement between the Secretary and the State shall provide for the DPA's establishment and maintenance of procedures for timely submission by applicants of written notice of capital expenditures subject to 1122 review. (42 C.F.R. §100.106(a)(1)).

The Court held that until the DPA promulgated rules for filing notices of intent and appeal procedures (in accordance with the rulemaking requirements of state law, which in this case required formal adoption pursuant to the state APA) the DPA was without authority to conduct an 1122 review program and make recommendations to the Secretary on proposed capital expenditures.

(2) *Heritage Regency, Inc. v. State Board of Health of Indiana as the Designated Planning Agency*
No. C-80-9441-C (Indiana Cir.Ct. Wayne County May 21, 1981)

A hospital brought an action seeking judicial review of a DPA decision making findings recommending denial of reimbursement under Section 1122 for a "comprehensive care" (nursing care) facility. The hospital alleged that the DPA erred in failing to promulgate rules to establish a procedure for appeal of negative 1122 recommendations. The Court held that the DPA's use of the administrative review procedures under the state APA was sufficient to satisfy the requirements of law for such an appeal procedure.

(3) *First Federal Savings and Loan Association of Lincoln v. Casari* 667 F.2d 734 (8th Cir. 1982), *cert. den.* 50
458 U.S. 1106 (1982)

A savings and loan association brought an action seeking to enjoin the DPA from recommending denial of reimbursement under Section 1122 of its project to acquire and reopen a nursing home and seeking to compel a favorable recommendation. The association had loaned money to construct the facility in 1972 and had acquired the facility, then closed, in lieu of foreclosure in December 1977. At the time the association filed its notice of intent to make a capital expenditure in October 1978, in connection with reopening the facility, the DPA had not formally adopted regulations governing 1122 notification and review procedures. The regulations were eventually adopted during the course of the DPA's review of the project. The association argued successfully in District Court that: (1)

the federal 1122 statute and regulations (in particular 42 C.F.R. §100.106(a)(1) which requires the DPA to establish and maintain procedures for timely notice of intent to make a capital expenditure) require the DPA to adopt 1122 notification and review regulations in the manner specified by the state APA; and (2) in the absence of such regulations the DPA lacked authority to act on the application.

The Court then affirmed the ruling that the DPA was powerless to act on the application by reason of its failure to adopt regulations. Section 1122 requires 60 day prior notification to the DPA of intent to incur an obligation for a capital expenditure, and provides that failure to notify is grounds for denial of reimbursement. Without deciding on which date the association's obligation was incurred, the Court concluded that the failure of the DPA to have established timely notice regulations in either 1972 or December 1977 deprived it of the authority to subsequently review the proposal. The Court upheld the District Court's order compelling the DPA to withdraw its negative recommendation, but reversed that portion of the order which directed an affirmative recommendation, on the grounds that lacking authority to review the proposal in any manner the DPA could logically assess neither conformance nor nonconformance.

(4) Nazareth Literary and Benevolent Institution, Inc. v. W. Grady Stumbo No. C-81-0637 L(A) (E.D.Ky. Dec. 4, 1981)

A hospital brought an action seeking to enjoin submission to HHS of a DPA decision, affirmed by a designated hearing officer, recommending denial of reimbursement under Section 1122 of its project to construct a new long-term care facility. The 1122 regulations require that the hearing officer notify the person requesting the hearing of his decision not more than 45 days after the conclusion of the hearing, with an untimely notification deemed an approval (45 C.F.R. §100.106(c)(3)). The petitioner's hearing concluded on August 25, 1981. The mailed decision was postmarked October 13, 1981 and received by petitioner's attorney on October 14, 1981, 50 days after the hearing ended. The 1122 regulations also require a DPA to establish and maintain 1122 notification and review procedures (42 C.F.R. §100.106). The DPA had not done so.

Among other things, the Court observed that the failure of the DPA to officially promulgate 1122 review regulations deprived it of authority to act, citing Nebraska Methodist, but declined to base its decisions on that ground because to do so could conceivably jeopardize the entire state 1122 program.

e. Time Periods for Administrative Appeals

(1) Sisters of St. Mary v. Percy No. 79-CV3785 (Wisc.Cir. Ct. Dane County Sept. 26, 1979)

A hospital brought an action seeking to have its application for reimbursement under Section 1122 of a project to acquire a CT scanner deemed approved. The DPA had issued a negative recommendation on Sept. 18, 1978. The hospital's request for a fair hearing was received by the DPA on Sept. 25, 1978. No hearing was commenced within thirty days thereafter. The federal 1122 regulations provide that following a negative recommendation an applicant may request a fair hearing which "shall be commenced within 30 days after receipt of the request." (42 CFR §100.106(c)(2)). The federal 1122 regulations also provide that applications are "deemed approved" if the DPA fails to take certain actions within specified time limits, such as rendering a final decision within 45 days after the conclusion of the fair hearing, (See, e.g. 42 CFR §100.106(a)(4), (c)(3), (5)), but does not set forth any adverse consequences for failure to provide a fair hearing within 30 days after the request. The Court held that the 30-day time limit for commencing a fair hearing was mandatory, not directory, because: (1) logic dictates that the legislature intended it to be mandatory since it would be anomalous to permit the DPA to delay indefinitely the commencement of the fair hearing while requiring a decision within a fixed time after the hearing's conclusion, and (2) the clear implication of a provision of Section 100.106(c)(2) which gives the applicant the right to request an extension of the 30-day period is that the DPA has no right to extend the time period on its own.

(2) Nazareth Literary and Benevolent Institution, Inc. v. W. Grady Stumbo No. C-81-0637 L(A) (W.D.Ky. Dec. 4, 1981)

A hospital brought an action seeking to enjoin submission to HHS of a DPA decision, affirmed by a designated hearing officer, recommending denial of reimbursement under Section 1122 of its project to construct a new long-term care facility. The 1122 regulations require that the hearing officer notify the person requesting the hearing of his decision not more than 45 days after the conclusion of the hearing, with an untimely notification deemed an approval (45 CFR §100.106(c)(3)). The petitioner's hearing concluded on August 25, 1981. The mailed decision was postmarked October 13, 1981 and received by petitioner's attorney on October 14, 1981, 50 days after the hearing ended. The 1122 regulations also require a DPA to establish and maintain 1122 notification and review procedures (42 CFR §100.106). The DPA had not done so.

The Court then enjoined the negative recommendation, holding that the timely notification rule requires actual delivery of the hearing officer's decision to the hearing requestor, not just mailing of the decision or placing a copy of the decision in official mailing channels, within 45 days after the hearing. [In 47 Fed. Reg. 7230 (Feb. 18, 1982) DHHS announced a new interpretive ruling providing that notice under the three required notice provisions of the 1122 regulations will be effective on the date the DPA or hearing officer mails to the applicant its finding. The three required notices are: (1) DPA notification to an applicant that additional information is required (42 CFR §100.106(a)(3); (2) DPA notification to the applicant as to whether the project is consistent with applicable criteria, etc. (42 CFR §100.106(a)(4); and hearing officer notification of his decision to the applicant (42 CFR §100.106(c)(3). This interpretive ruling applies by its own terms only to each initial determination by the Secretary made after Feb. 18, 1982. -- ED.]

(3) St. Joseph's Hospital, Inc. v. Sibley No. D-12402 (Georgia Super. Ct., Fulton Cty., Aug. 17, 1984)

A hospital brought a mandamus action seeking an order directing the state CON appeals board to conduct a hearing on its CON application. The board had apparently stayed the appeals hearing indefinitely. The Court granted the hospital's petition and ordered the board to set a date certain for hearing, holding that the board's indefinite staying of the appeal was a constitutionally impermissible denial of the hospital's right of access to the courts.

f. Scope of Review

(1) 1122 DPA fair hearing

(A) Humana Medical Corporation v. Schweiker No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. The Secretary of DHHS had excluded reimbursement on the overrun costs for one year after receiving a DPA recommendation that it do so. The hospital requested and was denied a fair hearing on the one-year exclusion by the DPA. When the fiscal intermediary denied reimbursement on account of the DHHS exclusion, the hospital appealed the denial to the PRRB (the Medicare administrative appeals board) and, following the PRRB's refusal to take jurisdiction on the question of the propriety of the Secretary's exclusion, brought this action. In this action, the hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc. treated elsewhere in the GUIDE. On the merits of the 1122 DPA fair hearing issue, the Court held that the DPA was not required under Section 1122(b) (42 U.S.C.A. §1320a-1(b)) to provide the hospital with a "fair hearing" on the question of whether the DPA received timely notice because: (a) the statute requires a DPA hearing only on a finding that the project is inconsistent with the review criteria; (b) the 1122 regulations, which are entitled to judicial deference, do not provide for a hearing on timely notice (42 CFR §100.106(a)(4)(iii)); and (c) DHHS, not the DPA, determines whether timely notice was given.

(B) *Louisiana Dept. of Health and Human Res. v. Hearing Officer, Section 1122 Appeal* No. 267,252 (La. 19th Jud. Dist.Ct. Parish of E.Baton Rouge, June 10, 1983)

A DPA brought an action seeking to enjoin its Section 1122 hearing officer from conducting an 1122 fair hearing as a *de novo* hearing on the merits. The Court refused to grant the injunction, holding that the "fair hearing" provided by 42 U.S.C. §1320a-1 and state regulations promulgated thereunder was to be conducted under the state APA as a *de novo* hearing on merits.

(C) *Health Quest Corp. v. Ellis* No. IP83-1046-C (U.S.D.C., S.D. Ill. July 12,1984), CCH, MEDICARE & MEDICAID GUIDE ¶ 34,176.

A nursing home corporation brought an action seeking mandamus to compel DHHS to certify as eligible for reimbursement the capital costs associated with two projects reviewed in 1978 under Section 1122 for construction of nursing homes. The DPA had initially prepared a negative recommendation respecting each project on the grounds of inconsistency with the "Bed Guide", an unpublished review criterion. In one case a fair hearing officer reversed the negative recommendation on the ground that the Bed Guide was an invalid criterion because it had not been promulgated as a regulation under the state APA. In the other case a state court vacated the DPA decision on the same legal ground. In both cases the DPA then submitted a favorable recommendation to DHHS. DHHS refused to reimburse, reasoning that the decisions of the hearing officer and state court did not reverse or modify the initial DPA decisions that the projects were inconsistent with the Bed Guide; that state law should not have been used to void the Bed Guide; and that, using federal law, the Guide was valid and should be used to deny the applications.

Section 1122 law and regulations provide that the DPA shall make and submit to DHHS findings as to whether a proposed capital expenditure is or is not consistent with standards, criteria, or plans developed pursuant to the Public Health Service Act. (42 U.S.C. §1320a-1(b); Soc. Sec. Act §1122(b); 42 C.F.R. §§100.104, 104(a)(2)). The DPA must grant the project proponent an opportunity for a fair hearing with respect to such findings and may provide for judicial review. (42 U.S.C. §1320a-1(d)(1); Soc. Sec. Act §1122(d)(1); 42 C.F.R. §100.106(c)). DHHS may determine that reimbursement will be withheld when an applicant fails to submit a timely application or when the DPA makes a finding of non- conformity with the review criteria in accordance with required procedures. (Soc. Sec. Act §1122(d); 42 U.S.C.A. §1320a-1(d); 42 C.F.R. §100.108(a)). Finally, determinations by the Secretary of DHHS under Section 1122 shall not be subject to administrative or judicial review. (Soc. Sec. Act §1122(f); 42 U.S.C.A. §1320a-1(f); 42 C.F.R. §100.108(e)).

The Court issued the writ, ruling among other things that mandamus could properly issue because DHHS had a clear, ministerial duty to certify the projects' costs eligible for reimbursement. DHHS' argument that state law could not invalidate the Bed Guide because to be valid the Bed Guide need only be a "standard, criteria, or plan developed pursuant to the Public Health Service Act" was wrong because: (a) DHHS' argument would eviscerate the Section 1122 statutory requirement for a fair hearing by denying the hearing officer power to decide issues of law; (b) DHHS' position would require state officials bound by oath and statute to execute state law to ignore that law; (c) the fact that DHHS had proposed regulations restricting state 1122 hearing officers' power to inquire into the validity of 1122 standards, criteria, and plans [*See* 48 Fed.Reg. 36399 *proposing to adopt* 42 C.F.R. §125.114(a) (4) (Aug. 10, 1983)] made obvious the fact that the existing regulation did not clearly proscribe hearing officer review of the propriety of the standards; and (d) DHHS' 1122 contract with the state provided for the hearing officer to comply with state law.

(2) HHS review of Sec. 1122 DPA decisions

(A) *Hollingsworth v. Schweiker* 664 F.2d 526 (Fifth Cir. 1981), *connected case sub. nom.* *Hollingsworth v. Harris* 608 F.2d 1026 (Fifth Cir. 1979)

A nursing home brought an action seeking judicial review of the Secretary of HHS's approval for reimbursement under Section 1122 of its competitor's project to construct a nursing home. The plaintiff alleged that the required public notice of the fair hearing on the competitor's 1122 application incorrectly stated the date of the hearing and that as a consequence it was denied the opportunity to appear and testify at the hearing. The hearing officer had failed to issue an opinion within 45 days after the hearing, with the consequence that the application was "deemed approved" by the state (*see* 42 C.F.R. §100.106(c)(3)). HHS approved the project for reimbursement. The plaintiff alleged that HHS erred in approving the project after the DPA failed to correctly follow the hearing notice procedures. The Court held that the Section 1122 statutory and regulatory provisions setting forth the Secretary of HHS's scope of review of a DPA decision (42 U.S.C.A. §1320a-1(d)(1); 42 CFR §100.108) do not require the Secretary to review the hearing notice given in each case. They require the Secretary to deny reimbursement only if the DPA did not receive notice of the capital expenditure or if the DPA disapproved the application. The Court specifically found that the statement in *NAACP v. Wilmington Medical*

Center and Wilmington United Neighborhoods v. United States that if the 1122 application is approved by the DPA the Secretary "performs the ministerial act of assuring that the proper procedure has been followed" refers only to the Secretary's enumerated responsibilities under the statute and regulation.

(B) Huron Valley Hospital, Inc. v. City of Pontiac 585 F.Supp. 1159 (E.D. Mich. 1984) ("Huron v. Pontiac II")

Proponents of a new hospital construction project (HVH) brought an action seeking judicial review of a DHHS administrative decision to withhold reimbursement under Section 1122 for capital costs associated with the project. This action was brought as an additional count in HVH's pending antitrust/civil rights lawsuit against various state and local officials and entities and various competitors, which was originally filed shortly after a 1977 SHPDA/DPA denial of its CON/1122 application to construct the project. Huron v. Pontiac I, supra. The state agency CON denial had been successfully appealed by HVH. Huron Valley Hospital v. Michigan State Health Facilities Commission [HVH v. MHFC], infra. In that case the state courts had held that the SHPDA erred by basing its decision on invalid criteria which had not been properly adopted as regulations or updated by current data. State proceedings on the 1122 denial had been suspended by agreement of the parties since 1977.

Section 1122 law and regulations provide that the DPA shall make and submit to DHHS findings as to whether a proposed capital expenditure is or is not consistent with 1122 review criteria. (Soc. Sec. Act §1122(b); 42 U.S.C.A. §1320a-1(b); 42 C.F.R. §100.104, 104(a)(2)). They also provide that DHHS may determine that reimbursement will be withheld when an applicant fails to submit a timely application or when the DPA makes a finding of non-conformity with the review criteria in acordance with required procedures. (Soc. Sec. Act §1122(d); 42 U.S.C.A. §1320a-1(d); 42 C.F.R. §100.108(a)). Finally, they provide that determinations by the Secretary of DHHS under Section 1122 shall not be subject to administrative or judicial review. (Soc. Sec. Act §1122(f); 42 U.S.C.A. §1320a-1(f); 42 C.F.R. §100.108(e)).

DHHS had ruled in its administrative decision that since its determination under Section 1122(d) is based on the DPA's finding as to conformity with the review criteria, it must ascertain whether such a finding has actually been made. In this case, the DPA had originally submitted a finding of non-conformity in 1977 based on the review criteria it used in both CON and 1122 review. In 1983 the DPA had submitted a purported revised finding that the project was in conformity. Based on the facts and circumstances surrounding the revised finding, DHHS concluded that the purported revised finding of conformity was invalid because the DPA had not, in fact, presently concluded that the project was in conformity with the criteria. Instead, it had concluded that the review criteria on which it might base a finding of non-conformity were invalid under the authority of HVH v. MHFC. DHHS took the position that the holdings of HVH v. MHFC did not support a finding of 1122 conformity because: (1) HVH v. MHFC addressed the CON denial, not the 1122 finding; and (2) HVH v. MHFC actually concluded that the project was inconsistent with the review criteria and although it found the criteria invalid for purposes of state CON and administrative procedural law, those laws did not invalidate the criteria for purposes of 1122 review.

The Court issued a writ of mandamus ordering DHHS to reinstate HVH's Section 1122 approval, holding that: (1) Section 1122(f) did not foreclose judicial review of DHHS's decision because Section 1122(f) only precludes review of the two determinations by DHHS specified in 1122(d) - the determination regarding lack of timely notice and the determination in a situation where the state DPA has made a negative finding - and neither of these determinations occurred in this case; and (2) DHHS lacked authority to render its decision in this case because the two 1122(d) determinations are the only determinations the Secretary can make under Section 1122. The Court rejected DHHS's argument that its decision merely implemented its duty to determine that the DPA approval followed the proper procedures, citing Hollingsworth v. Schweiker for the proposition that the only procedure for DHHS to consider in a case where a state DPA has issued a positive recommendation is whether or not the timely notice requirement was met by the project proponent.

(C) Health Quest Corp. v. Ellis No. IP83-1046-C (U.S.D.C., S.D. Ill. July 12,1984), CCH, MEDICARE & MEDICAID GUIDE ¶ 34,176.

A nursing home corporation brought an action seeking mandamus to compel DHHS to certify as eligible for reimbursement the capital costs associated with two projects reviewed in 1978 under Section 1122 for construction of nursing homes. The DPA had initially prepared a negative recommendation respecting each project on the grounds of inconsistency with the "Bed Guide", an unpublished review criterion. In one case a fair hearing officer reversed the negative recommendation on the ground that the Bed Guide was an invalid criterion because it had not been promulgated as a regulation under the state APA. In the other case a state court vacated the DPA decision on the same legal ground. In both cases the DPA then submitted a favorable recommendation to DHHS. DHHS refused to reimburse, reasoning that the decisions of the hearing officer and state court did not reverse or modify the initial DPA decisions that the projects were inconsistent with the Bed Guide; that state law should not have been used to void the Bed Guide; and that, using federal law, the Guide was valid and should be used to deny the applications.

Section 1122 law and regulations provide that the DPA shall make and submit to DHHS findings as to whether a proposed capital expenditure is or is not consistent with standards, criteria, or plans developed pursuant to the Public Health Service Act. (42 U.S.C. §1320a-1(b); Soc. Sec. Act §1122(b); 42 C.F.R. §§100.104, 104(a)(2)). The DPA must grant the project proponent an opportunity for a fair hearing with respect to such findings and may provide for judicial review. (42 U.S.C. §1320a-1(d)(1); Soc. Sec. Act §1122(d)(1); 42 C.F.R. §100.106(c)). DHHS may determine that reimbursement will be withheld when an applicant fails to submit a timely application or when the DPA makes a finding of non- conformity with the review criteria in accordance with required procedures. (Soc. Sec. Act §1122(d); 42 U.S.C.A. §1320a-1(d); 42 C.F.R. §100.108(a)). Finally, determinations by the Secretary of DHHS under Section 1122 shall not be subject to administrative or judicial review. (Soc. Sec. Act §1122(f); 42 U.S.C.A. §1320a-1(f); 42 C.F.R. §100.108(e)).

The Court issued the writ, holding among other things that DHHS lacked the authority to "look behind" the recommendations to approve the proposed expenditures conveyed to it by the DPA because Section 1122(d) and Section 100.108 give the Secretary no power to reject a state's recommendation that an expenditure be reimbursed and, just as the Secretary cannot overturn the state's recommendation directly, she cannot do so indirectly. She is not given power to reinterpret the state's report that the proposed expenditure should be reimbursed.

(D) Cf. In re Basic American Medical Inc. 1122 RECONSIDERATION (letter from Robert Graham to Merrily Munther dated April 3, 1985)

A life care community requested DHHS reconsideration of a favorable determination of reimbursement under Section 1122 for its competitor's project to construct a life care community. The petitioner argued that the DPA erred in failing to comparatively review the project with its similar, contemporaneously-filed application, and requested DHHS to remand the application to the DPA for comparative review. DHHS declined to do so, observing that where, as here, the proponent of a capital expenditure gave timely notice and the DPA made a finding of conformity with the 1122 criteria, DHHS lacked the authority to look behind the finding of conformity and to remand the matter to the state.

(3) CON

(A) Shenango Valley Osteopathic Hospital v. Commonwealth Department of Health 451 A.2d 434 (Pa. 1982), vacating and remanding No. 418 C.D. 1982 (Pa. Cmwlth.Ct. April 14, 1982)

A hospital brought an action seeking: (1) judicial review of a state agency determination that its acquisition of a CT scanner was subject to CON review; (2) declaratory and injunctive relief relating to the constitutionality of the CON statute; and (3) interim special relief permitting it to operate the scanner while its application for a CON to acquire the equipment underwent review by the state and local health planning agencies. Without obtaining a CON, the hospital had purchased and accepted delivery of the $268K scanner in July and August of 1981, at which time the state CON statute covered capital expenditures in excess of $165K. On October 1, 1981 the statute was amended, increasing the capital expenditure threshold to $600K but continuing coverage of any "addition of a health service" regardless of the value of the capital expenditure associated with the health service addition. The state agency then determined that the acquisition was covered as a health service addition and ordered the hospital not to operate the scanner until it obtained a CON. The hospital appealed the agency's coverage determination to an administrative appeals board (the State Health Facility Hearing Board), filed a CON application, and brought this action, in which among other things it raised constitutional objections to the CON statute on vagueness and unlawful delegation grounds.

The Court ruled that the hospital's action was not barred by failure to exhaust administrative remedies because exhaustion is not required where, as here, equitable relief is sought, a substantial question of constitutionality is raised, and there is no adequate administrative remedy. The Court concluded that: (1) no administrative remedy was available because the State Health Facility Hearing Board's express grant of jurisdiction in the state CON statute did not include the authority to pass upon the constitutionality of the CON statute, nor could it be reasonably inferred given the Board's makeup and expertise; and (2) neither were the constitutional challenges within the purview of the state agency.

(B) Cf. In re Rev. of Dec. of Kansas Corp. Com'n 659 P.2d 199 (Kan. 1983)

A competitor (Bethany Medical Center) brought an action appealing the decision of KCC (the state agency which heard administrative appeals of CON decisions) to grant a CON to Providence-St. Margaret Health Center to acquire a 6MeV linear accelerator. KCC had reversed the SHPDA denial of the application.

At the time of the Providence application there were four linear accelerators in the service area: two low energy units and two extra high energy units, all located at a university hospital. In addition, after the SHPDA decision but prior to the KCC decision the State Supreme Court had affirmed an earlier KCC decision granting Bethany a CON for a low-energy linear accelerator. (*In re Certificate of Need Application by Bethany Medical Center, infra*.) The state used the linear accelerator need methodology set forth in the National Guidelines for Health Planning (42 C.F.R. §121.209) which among other things provided that: (1) each unit should serve a population of 150K and treat 300 cancer cases annually; (2) no additional units should be approved until all existing general purpose units in the area were performing 6,000 treatments per year; and (3) "dedicated special purpose and extra high-energy machines which have limited but important applications may not perform 6,000 treatments per year and should be evaluated individually by HSAs in the (42 C.F.R. §121.209(b)).

The SHPDA had "individually evaluated" the extra high-energy machines by treating the two as if they were one machine for purposes of the need formulae (giving the area three or four existing units, depending upon whether Bethany's unit was counted) and apparently had denied on the grounds that the population/unit and cancer cases/unit formulae projected a need for fewer than four units. KCC "individually evaluated" the two machines by excluding them altogether from consideration in applying the need formulae.

At the time of these proceedings, the state CON statute provided that the KCC review hearing would be on the record and not a *de novo* hearing, that the KCC decision would set forth findings of fact and a determination of the issues presented, and that the decision might approve or disapprove the decision of the state agency. (Kan.Stat.Ann. 65-4812, 4814 (1980)).

Apparently concluding that KCC's jurisdiction was limited to considering whether there was substantial evidence in the record to support the SHPDA's decision, the Court held that KCC erred in overturning the SHPDA decision because in doing so KCC ignored the SHPDA's "individual evaluation" of the two extra high energy units.

20. Changes In Review Procedures While Application Pending

a. *Humana Medical Corporation v. Schweiker* No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. On November 24, 1970 the hospital had acquired an adjacent facility with a view toward expanding its existing plant. On December 21, 1972 it applied for a CON for a 55 bed expansion/renovation project on the site. On December 29 or 30, 1972 the hospital poured a concrete footing for a construction project on the site. On April 15, 1973 it received a CON for the project, valid for six months and showing an estimated cost of $750K. On Sept. 26, 1973 it entered into a construction contract for Phase I of the project. Following completion of Phase I the hospital entered into a contract for Phase II on July 1, 1974 at a stated cost of $1.6M. Phase II was completed in July 1976 at a total project cost of $3.3M.

On October 30, 1972 Congress had passed P.L. 92-603, which adopted the Section 1122 program and which contained a provision (the so-called "221(b) effective date") stating that the Section 1122 program would apply only with respect to capital expenditures incurred subsequent to the earlier of December 31, 1972 or the last day of the calendar quarter in which a State requested that the program apply (P.L. 92-603 §221(b) not codified; See 42 U.S.C.A. §1320a-1 Historical Note). Federal regulations provide for coverage under Section 1122 of capital expenditures incurred after December 31, 1972 or the effective date of a DPA Agreement, whichever is later, and permit the Agreement's effective date to be earlier than its signing date if DPA procedures utilized as of the earlier date satisfy DHHS (42 CFR §100.103). The Alabama DPA issued an 1122 Procedures Manual effective September 18, 1973 and on February 27, 1974 the state entered into a DPA Agreement with DHHS, antedated to Sept. 18, 1973, eight days before the hospital's Phase I contract.

In late 1976 Medicare fiscal intermediary auditors warned the hospital that under Section 1122 it would not be able to receive reimbursement for capital costs associated with the costs in excess of the amount on the April 1973 CON for the project without DPA approval. In response the hospital applied for and received DPA approval on March 21, 1977 of the costs in excess of $750K. In January 1977 DHHS had issued a Policy on Lack of Timely Notice (Section 1122 Notice 77-01; 42 Fed. Reg. 4847 (January 26, 1977); 42 CFR §100.108 Note (1981)) providing that when a person neglects to submit an 1122 application within 60 days prior to incurring a capital expenditure as required by Section 1122 DHHS will withhold reimbursement for one year. Pursuant to the policy, at the DPA's recommendation the Secretary of DHHS decided to exclude reimbursement for one year on the costs in excess of the amount on the original CON. The hospital requested and was denied a fair hearing on the one-year exclusion by the DPA. When the fiscal intermediary denied reimbursement on account of the DHHS exclusion, the hospital appealed the denial to the PRRB (the Medicare administrative appeals board) and, following the PRRB's refusal to take jurisdiction on the question of the propriety of the Secretary's exclusion, brought this action.

The hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc. dealt with elsewhere in the GUIDE. Additionally, it argued that application of the Policy on Lack of Timely Notice to it was an unconstitutional retroactive application of law in violation of due process. The Court rejected this argument, holding that: (a) although the project predated the Policy by several years, the 1122 statute and regulations and the Policy were in effect at the time of the initial and reconsideration decisions by DHHS on the timeliness of the hospital's 1977 1122 applications and DHHS must apply the law in effect at the time it renders its decisions; and (b) applying the Policy worked no manifest injustice on the hospital because it voluntarily entered a regulatory program and was presumed to be aware that occasional changes would be made to better carry out the regulatory purposes; and (c) the Policy did not change the hospital's vested rights or add to its obligations.

b. Olathe Community Hospital v. Kansas Corporation Commission 652 P.2d 726 (Kan. 1982)

A hospital which had been granted a CON brought an action seeking a judicial determination whether its competitor's appeal of the CON should be lodged in an administrative appeals board (KCC) or in a trial court. Effective July 1, 1982 the state CON statute was amended to repeal the requirement that SHPDA decisions be administratively reviewed by the KCC before judicial review would be permitted (with the request for administrative review filed within 30 days after the SHPDA decision) and to permit direct appeal to court with a similar 30-day period. On June 18, 1982 petitioner received its CON and on July 14 and 16 respectively the competitor filed notices of appeal in both KCC and the local trial court. The Court held that the administrative appeal in the KCC should be dismissed and the appeal heard in the trial court because statutory procedural changes may be applied to pending disputes and administrative appeals are not a matter of right.

c. State ex rel. Southwest Community Health Services v. Monroe 659 P.2d 315 (N.M. 1983)

A hospital which had been awarded a CON brought an action seeking a writ of prohibition against the processing of an administrative appeal of its CON brought by a competitor. The 1978 state CON statute provided for administrative appeals only at the request of the applicant. In 1981 the statute was amended to provide for administrative appeals at the request of any affected person. The 1981 amendments became effective on July 1, 1981. A transition "effective date" provision in the regulations implementing the 1981 amendments provided that the revised regulations would apply to all applications received after July 1, 1981.

The hospital hand-delivered its application on June 30, 1981 and the application was deemed complete on August 6, 1981. The hospital argued that the statute permitting a competitor to bring an administrative appeal did not apply to its application because it had been received before July 1, 1981. The Court held that the 1981 statute granting competitors standing to appeal did apply because: (1) the key date triggering action on a CON application (such as transmittal of the application to the HSA, giving notice to affected persons, and calculation of the time periods for HSA and SHPDA review) under both the 1978 and 1981 statute was the date the completed application was received; (2) although the application was submitted before July 1, 1981 it was deemed received for purposes of determining whether the 1981 or the 1978 statute applied on the date it was deemed complete. (Apparently the Court applied the "effective date" provision in the 1981 regulations to the statute - Ed.)

d. Cf. Loyd v. Georgia State Health Planning and Development Agency 310 S.E.2d 738 (Ga. App. 1983)

Several area residents brought an action seeking judicial review of the decision of the State Health Planning Review Board (SHPRD), an administrative appellate body, that they lacked standing to obtain administrative review by the SHPRD of the issuance by the SHPDA of a CON. The trial court ruled that the petition for judicial review was fatally defective because it failed to name the SHPRD as a party respondent, necessary because the SHPRD was the body which made the decision by which the petitioners were allegedly aggrieved. At the time the trial court reached its decision the state CON statute granted standing to obtain SHPRD administrative review to any person who qualified as a "party" or "person aggrieved" under the state APA. While the area residents' appeal of the trial court decision was pending before the Court of Appeals, the CON statute was amended to limit standing to applicants, competitors, and local governments.

The Court of Appeals ruled that the area residents lacked standing because: (1) Since no vested rights were involved, the Court was required to decide their claim under the law as it existed at the time of its judgement, rather than the law prevailing at the rendition of the judgement under review; and (2) under the amended law, the area residents lacked standing.

e. Cf. Alameda-Contra Costa Health Systems Agency v. Office of Statewide Health Planning and Development No. 817529 (Calif. Super. Ct., San Francisco Cty. Sept. 5, 1984)

An HSA brought an action seeking judicial review of SHPDA decisions awarding CONs to six competing CON applicants for new hospital construction/modernization. The HSA had recommended denial of all six applications in late 1983. Following an HSA request, the SHPDA briefly commenced and then recessed hearings on the applications. In late 1983 and early 1984 the state issued CONs to each of the applicants without adopting formal findings or submitting statements of reasons for its decisions to the HSA. At the time of HSA's hearing request, state law required the SHPDA to conduct hearings on CON applications if requested by an HSA. The HSA hearing request provision was repealed in 1984 prior to the Court's decision. The HSA sought relief in the form of, among other things, a court order revoking the CONs and compelling the SHPDA to conduct hearings on the applications, adopt findings, and provide a statement of reasons to the HSA.

In the course of granting the HSA relief, the Court held that the HSA's right to a hearing under state law was eliminated by the 1984 repeal of the statutory authorization for the request because as a public agency the HSA did not have a vested right to the hearing and a court order would not issue to enforce statutory provisions no longer in effect.

f. Roman Catholic Diocese of Albany v. New York State Dept. of Health 490 N.Y.S.2d 636 (App.Div. 1985)

Religious organizations and individual health care consumers brought an action seeking judicial review of a state agency decision granting a CON to a birth control clinic to add abortion services. In the course of overturning the state agency decision, the Court first held that the petitioners had the right to seek judicial review of the state agency's determination under NHPRDA and its companion regulations because: (1) A State's adherence to a CON program is a condition of receiving federal financial assistance under NHPRDA; (2) New York has legislatively opted to participate in the federal program; (3) having opted to participate in and receive the financial benefit of the CON program under NHPRDA, New York is bound by the provisions thereof insofar as they mandate access to an appropriate state court for the purpose of challenging a state agency decision; (4) NHPRDA grants the right to judicial review to "persons adversely affected"; (5) federal regulations in effect at the time of the initiation of this proceeding defined the foregoing phrase to include any person residing within the geographical area to be served under the application, regularly using health care services in the area, or participating in the proceeding before the state agency [42 C.F.R. §123.401, 410(14) (1981) (amended 1985)]; (6) the regulations are controlling over any state restriction on access to the courts by persons having a federal right to review of state agency CON decisions; and (7) each of the petitioners was either a resident of the geographical area affected by the proposed project or participated personally or through a representative in the administrative proceeding. Therefore, each has a federally-created right to seek judicial review and each has statutory standing. The Court rejected the state agency's argument that petitioners' NHPRDA right to judicial review was eliminated by federal CON regulation amendments adopted January 14, 1985 during the pendency of these proceedings which deleted the regulatory definition of "affected persons." It held that the regulatory amendment should not be applied to undo standing already validly acquired because there was nothing to indicate that the deletion was intended to restrict standing to obtain judicial review of CON decisions or that it was designed to apply retroactively to already pending judicial review proceedings in which a party had valid standing when the proceeding was commenced.

21. Settlement of Administrative Review Proceedings

a. State ex rel. Pilot Development Northwest, Inc. v. State Health Planning and Development Bureau 701 P.2d 390 (N.M. App. 1985)

A nursing home (Pilot) brought an action in mandamus seeking a court order declaring void the DPA's decision recommending approval of its competitor Americare's bed construction project pursuant to a settlement negotiated during an administrative appeal between the DPA and Americare.

Pilot had applied for approval of 90 ICF beds. Americare applied initially for 84 ICF/36 SNF. The SHP showed a need for 90 ICF. The applications were batched. The DPA decision approved Pilot's application and denied Americare. By this time the SHP need had grown to 162 ICF. Americare was granted an administrative appellate fair hearing on its denial and Pilot's approval. While the hearing was pending, Americare negotiated a settlement with the DPA under which its administrative appeal was dismissed and the DPA agreed to approve its application as amended to 72 ICF/24 SNF/24 personal care beds not subject to 1122 review. Pilot responded with its mandamus action. The trial court issued a writ of mandamus declaring the settlement void, invalidating Americare's amendment of its application during appeal, and ordering the amended application reviewed anew. The Appeals Court affirmed the trial court's issuance of the writ, holding that: (1) the DPA had the implied power under Section 1122 law and regulations to settle the administrative appeal, as long as the terms of the settlement were consistent with 1122 law and regulations; (2) Section 1122 regulations (42 C.F.R. §100.103(a)(2)(v)) require full review of a change in a proposed capital expenditure which is itself a reviewable transaction and the reduction of 12 SNF and 12 ICF beds in the amended Americare application was a reviewable capital expenditure resulting in a decrease in licensed capacity. The Court rejected Americare's contention that bed capacity was unchanged because the initial application and the post-settlement application proposed 120 beds, noting that the distribution of beds among bed categories had changed and that the 24 personal care beds of the settlement were not subject to approval and thus were not to be counted in bed capacity requiring approval; (3) the full review procedures were not followed. The Court observed that the effect of the approval of the Americare proposal by settlement was that 72 beds were awarded to Americare without notice to interested parties, without local HSA review, and without an opportunity for Pilot or others to compete for such beds.

b. Florida Convalescent Centers, Inc. v. Dept. of Health and Rehabilitative Services 445 So.2d 631 (Fla.Dist.Ct.App. 1984)

A nursing home (FCCI) brought an action seeking a writ of prohibition preventing the state agency from granting a CON without an administrative hearing to its competitor (Catholic) pursuant to a settlement or stipulation negotiated between Catholic and the state agency.

FCCI's and Catholic's new nursing home construction applications had been "batched" and denied. Both FCCI and Catholic sought an administrative hearing on their respective denials. Later, FCCI requested intervention and consolidation with Catholic's administrative proceeding. The state agency denied the request on the grounds that Catholic had recently voluntarily dismissed its appeal. The state agency informed FCCI that it had entered into a stipulation with Catholic which provided that if Catholic would voluntarily dismiss its appeal, the state agency would grant its CON application in 30 days. At this point in time the state had not yet issued a CON to Catholic. FCCI then filed a second request for administrative hearing in which it requested that the state not issue the CON to Catholic until it comprehensively reviewed all pending applications at an administrative hearing. Without waiting for the state to act on its second request, FCCI also brought this action. The Court denied FCCI's writ petition as premature because the state agency still had jurisdiction to grant FCCI's second hearing request. However, the Court observed that the stipulation entered into by the state agency with Catholic was a preliminary, "free-form" agency action and any further action taken pursuant to the stipulation prior to the resolution of FCCI's second hearing request would be subject to attack for failure to comply with statutory requirements.

B. REVIEW CRITERIA AND STANDARDS

1. Requirement of Adoption of Review Criteria and Related Materials as Administrative Regulations

a. Adoption as Regulation Required

(1) Sturman v. Ingraham 383 N.Y. S.2d 60 (App.Div. 1976)

A nursing home operator brought an action seeking judicial review of the state agency's decision denying her application for approval of an expansion project. The application was denied on the basis of lack of need as indicated in a state agency document which identified the need for LTC beds in each county in the state and provided that since 95% of the need in Westchester County (where plaintiff's facility was located) was satisfied, no further approvals were indicated at the time. The Court reversed the state agency decision, ruling in an alternate holding that the state agency decision was arbitrary because the state guideline was a regulation (a rule of general applicability) which had not been properly adopted and therefore was void. The Court remanded to the state agency for rehearing.

(2) Cheshire Convalescent Center, Inc. v. Commission on Hospitals and Health Care 386 A.2d 264 (Conn. C.P. New Haven County 1977)

A nursing home brought an action seeking judicial review of a state agency decision denying its application for a CON to construct a 120-bed addition to its facility. The state agency had denied application on the basis of absence of need as measured by a bed/population ratio adopted as a guideline by the state. The Court struck down the agency's decision, holding that the bed need criterion was invalid on the grounds that it had not been promulgated as a regulation in accordance with the state APA. It was an agency statement of general applicability that implements, interprets, or prescribes agency policy, and thus was required to be formally adopted as a regulation. The Court remanded to the agency to reconsider the application without reliance on the invalid criterion.

(3) Cf. Stamford Hospital v. Commission on Hospitals and Health Care No. 17334 (Conn.Ct.C.P. Fairfield County Jan. 27, 1978)

A hospital brought an action appealing the decision of the state agency denying its application for a CON to acquire a CT scanner. The state CON statute authorized the state agency to consider several enumerated general factors in reviewing CON applications and authorized the agency to consider such other relevant factors as it deemed necessary. The state agency was in the process of developing regulations containing CON criteria at the time the hospital's application was reviewed and various studies and reports of criteria used by other agencies were being considered by the agency. The Court found that the state agency failed to identify the criteria and standards it intended to use to review the application and failed to apply the standards it did use in a reasonable manner.

(4) North Miami General Hospital Inc. v. Office of Community Medical Facilities 355 So.2d 1272 (Fla.Dist.Ct.App. 1978)

A hospital brought an action seeking judicial review of a DPA decision recommending denial under Section 1122 of its project to acquire a CT scanner. The DPA recommended denial on the basis of absence of need, which it measured by a standard providing that no need was present until existing CT scanners in the area were performing 2,400 scans per year. The Court reversed the DPA decision and held, in an alternative holding, that the DPA should not have used the 2,400 scans per year formula in calculating need because even if it were a proper measure of utilization it had never been officially adopted and promulgated as a regulation under the state APA.

The DPA had also attempted to present sufficient evidence in the hearing it held on the hospital's application to justify the use of the unadopted 2,400/year utilization rate as a standard to determine need. The Court held that the DPA failed to present sufficient substantial evidence to support the standard.

(5) Cf. Dobbs Ferry Hospital Association v. Whalen 403 N.Y.S. 2d 304 (App.Div. 1978)

A hospital brought an action seeking judicial review of the state agency's disapproval of its application for a project to replace its outdated facilities. Disapproval was based on lack of public need. The Court reversed the state agency decision, ruling that the disapproval was arbitrary and capricious because the state agency regulations did not provide for denial of approval on that ground.

(6) *Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission* No. 80-200439-AA (Mich.Cir.Ct. Oakland County March 27, 1981), *aff'd*, 312 N.W. 2d 422 (Mich.App. 1981)

A hospital corporation brought an action seeking judicial review of a SHPDA denial of its application for a CON to construct a new hospital. The SHPDA's denial was based in part on an unpublished but regularly used criterion establishing a preference for existing facilities. The Court struck down the state agency decision, holding among other things that the criterion was invalid because it had not been formally adopted as a regulation. It should have been adopted as a regulation because it was an agency standard or policy which implemented the law that the state agency administered.

(7) *Cf. Westchester General Hospital v. State Department of Health and Rehabilitative Services* 417 So.2d 261 (Fla. Dist.Ct.App. 1982)

A hospital brought an action challenging a state agency regulation which implemented a statutory amendment repealing certain grandfather exemptions from CON. The state APA required that an economic impact statement accompany newly-adopted regulations. Over a dissent which argued that the economic impact resulted from the statute, not the regulation, the Court upheld a hearing officer's decision striking down the regulation for failure to address the cost impact of the regulation on hospitals.

(8) *Wisconsin Hospital Association v. State Dept. of Health, et al.* No. 82-CV-2653 (Wisc.Cir.Ct., Dane Cty., Mar. 8, 1983)

A hospital association brought an action seeking a declaratory judgement that the state's statutory CON moratorium conflicted with NHPRDA and thus was unconstitutional under the Supremacy Clause; and that the informal procedures used by the SHPDA to administer the moratorium were invalid because not formally promulgated as regulations. The Court ruled for the hospital association, holding that the "Procedures for Moratorium Implementation," a SHPDA document containing guidelines for calculating coverage and exemptions from the moratorium, was an agency statement of general policy required to be promulgated by regulation. However, the Court refused to order the SHPDA to accept and process all CON applications, regardless of whether they were covered by the moratorium, until such time as regulations were adopted because the legislature did not require promulgation of rules in order to interpret and implement the statute and the statutory provision for the moratorium is clear and self-executing.

(9) Balsam v. Dept. of Health and Rehabilitative Services 452 So.2d 976 (Fla. Dist.Ct.App. June 13, 1984)

Proponents of a psychiatric hospital construction project brought an action challenging the validity of a SHPDA moratorium on CON reviews and apparently seeking an order compelling the SHPDA to review their CON application in a particular batching cycle. At the time plaintiffs filed their application the SHPDA had administratively imposed a time-limited moratorium on CON reviews for the stated purpose of allowing it time to promulgate rules on statewide bed-need methodologies required by recent legislation. The SHPDA informed plaintiff that it could re-file an application to be processed in the first post-moratorium batching cycle. The state CON statute required the SHPDA to review CON applications in no less than four batched reviews per year and the SHPDA had adopted batching cycle regulations. The Court ruled for plaintiffs, holding that the moratorium was an agency rule, invalid since not formally adopted as a regulation, because it was a statement of general applicability consistently applied to all applications during the time it was in force. The Court rejected the argument that the moratorium was not a rule because it had a stated finite duration. The Court also rejected the argument that the moratorium could best be characterized not as a rule but as a temporary suspension or deviation from the batching cycle regulations, noting that there were no provisions in the regulations which would allow suspension of a current rule or deviation from a promulgated rule and such suspension would be in direct contravention of the statutory requirement of review no less than four times per year.

(10) Health Quest Corp. v. Ellis No. IP83-1046-C (U.S.D.C., S.D. Ill. July 12,1984), CCH, MEDICARE & MEDICAID GUIDE ¶ 34,176.

A nursing home corporation brought an action seeking mandamus to compel DHHS to certify as eligible for reimbursement the capital costs associated with two projects reviewed in 1978 under Section 1122 for construction of nursing homes. The DPA had initially prepared a negative recommendation respecting each project on the grounds of inconsistency with the "Bed Guide", an unpublished review criterion. In one case a fair hearing officer reversed the negative recommendation on the ground that the Bed Guide was an invalid criterion because it had not been promulgated as a regulation under the state APA. In the other case a state court vacated the DPA decision on the same legal ground. In both cases the DPA then submitted a favorable recommendation to DHHS. DHHS refused to reimburse, reasoning that the decisions of the hearing officer and state court did not reverse or modify the initial DPA decisions that the projects were inconsistent with the Bed Guide; that state law should not have been used to void the Bed Guide; and that, using federal law, the Guide was valid and should be used to deny the applications.

Section 1122 law and regulations provide that the DPA shall make and submit to DHHS findings as to whether a proposed capital expenditure is or is not consistent with standards, criteria, or plans developed pursuant to the Public Health Service Act. (42 U.S.C. §1320a-1(b); Soc. Sec. Act §1122(b); 42 C.F.R. §§100.104, 104(a)(2)). The DPA must grant the project proponent an opportunity for a fair hearing with respect to such findings and may provide for judicial review. (42 U.S.C. §1320a-1(d)(1); Soc. Sec. Act §1122(d)(1); 42 C.F.R. §100.106(c)). DHHS may determine that reimbursement will be withheld when an applicant fails to submit a timely application or when the DPA makes a finding of non- conformity with the review criteria in accordance with required procedures. (Soc. Sec. Act §1122(d); 42 U.S.C.A. §1320a-1(d); 42 C.F.R. §100.108(a)). Finally, determinations by the Secretary of DHHS under Section 1122 shall not be subject to administrative or judicial review. (Soc. Sec. Act §1122(f); 42 U.S.C.A. §1320a-1(f); 42 C.F.R. §100.108(e)).

The Court issued the writ, holding among other things that mandamus could properly issue because DHHS had a clear, ministerial duty to certify the projects' costs eligible for reimbursement. (1) DHHS' argument that state law could not invalidate the Bed Guide because to be valid the Bed Guide need only be a "standard, criteria, or plan developed pursuant to the Public Health Service Act" was wrong because: (a) DHHS' argument would eviscerate the Section 1122 statutory requirement for a fair hearing by denying the hearing officer power to decide issues of law; (b) DHHS' position would require state officials bound by oath and statute to execute state law to ignore that law; (c) the fact that DHHS had proposed regulations restricting state 1122 hearing officers' power to inquire into the validity of 1122 standards, criteria, and plans [*See* 48 Fed.Reg. 36399 *proposing to adopt* 42 C.F.R. §125.114(a) (4) (Aug. 10, 1983)] made obvious the fact that the existing regulation did not clearly proscribe hearing officer review of the propriety of the standards; and (d) DHHS' 1122 contract with the state provided for the hearing officer to comply with state law. (2) DHHS' conclusion that the Bed Guide was properly developed pursuant to the Public Health Service Act was wrong because: (a) Section 1523(a)(4)(A) of NHPPDA (42 U.S.C. §300m-2 (a)(4)(A) governs DPAs; (b) Section 1532 (42 U.S.C. §300n-1) requires agencies performing review functions under Section 1523 to follow federal regulations, including 42 C.F.R. §123 *et seq.* [The Court cited 42 C.F.R. §123.402(a)(3)(1977)(*amended* 1980) for this proposition.]; (c) 42 C.F.R. §123.406 subjects review criteria to notice and comment requirements; and (d) the Bed Guide was not promulgated according to such requirements.

(11) Roman Catholic Diocese of Albany v. New York Dept. of Health 490 N.Y.S.2d 636 (App.Div. 1985)

Religious organizations and individual health care consumers brought an action seeking judicial review of a state agency decision granting a CON to a birth control clinic to add abortion services. A major factor in the agency determination to approve was the fact that existing abortion services in the area were apparently being performed largely on an inpatient basis while an unpublished agency criterion for judging need for abortion services (the "50% rule") provided that a public need for outpatient abortion services existed whenever less than 50% of all abortion services were available on an outpatient basis.

The Court ruled that the state agency decision was arbitrary and capricious because: (1) the decision was based in significant part on a numerical formula (the 50% rule); and (2) when a state agency bases its determination on a fixed standard it must be formally adopted as a regulation. Although the agency's decision was also based on several other factors, the Court refused to sustain the decision on those factors alone, holding that to do so would improperly substitute the court's judgment for that of the administrative agency.

b. Adoption as Regulation Not Required

(1) Fleetcrest Manor v. Commission on Hospitals and Health Care No. 032330-6 (Conn.Super.Ct. Waterbury Jud.Dist. June 15, 1981)

A rest home brought an action seeking judicial review of a state agency denial of its application for a CON to institute an alcoholism treatment program. The state agency denial was based on the state CON statute's review criteria and standards, not on criteria and standards contained in regulations. The Court held that the failure of the state agency to adopt regulations regarding CON criteria and standards did not render its decision void because the statutory criteria and standards adequately informed the applicant of the standards the agency would apply in rendering its decision on an application and the fact that the Commission did not further specify the statutory criteria by regulation did not support a grant of a certificate of need which would defy the expressed legislative policy.

(2) Heritage Regency, Inc. v. State Board of Health of Indiana as the Designated Planning Agency

No. C-80-9441-C (Indiana Cir.Ct. Wayne County May 21, 1981)

A hospital brought an action seeking judicial review of a DPA decision making findings recommending denial of reimbursement under Section 1122 for a "comprehensive care" (nursing care) facility. The hospital alleged that the DPA's use of the 1979 Guide to Hospital and Health Facility Bed Need (a state document which contained population projections, occupancy figures, and need formulae) was improper because the GUIDE had not been formally adopted as a regulation. The Court struck down the DPA decision, holding among other things that the Guide was not a regulation (which could not be used as a criterion until formally adopted) but merely a guideline, not employed as if it were a binding rule nor used to the exclusion of other considerations.

(3) Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission No. 80-200439-AA (Mich.Cir.Ct. Oakland County March 27, 1981), aff'd on other grounds, 312 N.W. 2d 422 (Mich.App. 1981)

A hospital corporation brought an action seeking judicial review of a SHPDA denial of its application for a CON to construct a new hospital. The SHPDA's denial was based in part on the State Plan for hospital and medical facilities construction which was a statutorily-mandated CON criterion. The Court struck down the state agency decision, holding among other things that the state was not required to promulgate the State Plan as an regulation before using it as a CON criterion because the State Plan was not a creation of the agency's rule-making power but rather a creation of the state legislature which mandated its preparation, defined its purpose, described its contents, and placed responsibility for its development and administration in the State Department of Public Health, including the responsibility for holding public hearings on it and notifying interested parties of its existence.

(4) Merry Heart Nursing and Convalescent Home, Inc. v. Dougherty 330 A.2d 370 (N.J.Super.App.Div. 1974)

A nursing home brought an action seeking judicial review of a state CON appeals board decision on its application for a CON to add beds to its facility. The board remanded the application to a state agency hearing officer with directions that the need for the project be reviewed for conformity with the State Plan for Health Care Services as updated shortly after the nursing home's CON application was filed. The Plan was first adopted and promulgated as a regulation on March 9, 1972. It was updated on June 29, 1972, by the addition of statistical data which had the effect of erasing the need indicated in the Plan for plaintiff's project. The update was not promulgated as a regulation. Plaintiff's application had been filed on March 21, 1972. The Court upheld the board's decision, holding that the project should be reviewed for conformity with the updated Plan because the change in the plan to reflect current statistical data was not an amendment which the agency was required to adopt as a regulation. As a practical matter construction of new facilities and closure of existing facilities effect immediate changes in areawide needs and the state would be derelict in its duty to determine need it if did not take into consideration the latest available information in passing on CON applications.

(5) Eagle Hill Corp. v. Commission on Hospitals and Health Care No. 2422 (Conn. Ct.App. May 29, 1984)

An alcoholism treatment hospital brought an action seeking judicial review of a Commission decision denying in part its April 1980 request for CON approval of a $705K cost overrun on its previously approved construction project. In 1976 the Commission had approved a $2.7 million capital expenditure to construct the facility. In January, 1979 it approved a $1.6 million overrun. From then till April, 1980 the hospital spent or committed itself to spend an additional $540K for various construction changes, and committed itself to an additional $165K capital expenditure to complete construction and additional financing costs, for a total of $705K. The Commission found that the hospital had inefficiently managed and monitored project costs and neglected to pursue its legal remedies against defaulting contractors or scale back project scope to hold costs to the previously-approved level. Consequently, it denied the $540K portion of the request. It approved the $165K portion with four conditions: (1) hospital submission of its annual operating and capital budgets upon the earlier of attainment of ninety percent occupancy or the end of the first year of operation; (2) annual submission of proposed budgets for six years; (3) hospital reporting of any estimated additional capital costs within one business day; and (4) a prohibition on additional changes in facility scope, cost, or services without the Commission's prior approval.

The Court ruled on various aspects of the Commission's decision. Among other things, the Court held that the Commission's decision did not constitute the promulgation of a regulation in violation of the state APA because: (1) the Commission did not announce a rule of general applicability; and (2) the fact that the Commission's decision had precedential significance did not transform it into a regulation.

(6) Mercy Health Center v. State Health Facilities Council 360 N.W.2d 808 (Iowa 1985), rev'g No. 44313 (Iowa District Ct., Dubuque County, Jan. 4, 1984).

A hospital brought an action seeking judicial review of a state health facilities council (SHFC) decision denying its application for a CON to convert its acute care facility into an "elder care center." The project involved, among other things, establishment of a new SNF unit and renovation of space to residential apartment, mini-shopping mall, and other non-medical uses. The SHFC denied the application on the grounds of oversupply of SNF beds in the community and because its financing arrangement would result in cross-subsidization (i.e., revenues from health care services would contribute to non-health care services which could be provided by non-health care industries).

The Court upheld the SHFC decision, holding that the SHFC's consideration of cross-subsidization was not a misapplication of the statutory criteria or an application of an unpromulgated rule because: (1) The statutory CON criteria are not exclusive in the sense of prohibiting the SHFC from considering matters not specifically enumerated in the statutory list of criteria, although the SHFC must consider the statutory criteria; (2) the SHFC's consideration of cross-subsidization was not the application of an unpromulgated rule, but rather an authorized application of the statutory criteria requiring consideration of immediate and long-term financial feasibility, probable impact on health service costs and charges, and availability of less costly, more efficient alternatives since cross-subsidization is a factual matter which bears directly on these considerations. Finally, the Court held that the SHFC's decision was supported by substantial evidence, observing that the case turned on the cardinal rule of administrative law that judgment calls are the province of the administrative tribunal and not of the courts.

(7) Manor Healthcare Corp. v. Northwest Community Hospital
472 N.E.2d 492 (Ill. App. 1984)

A competitor brought an action seeking judicial review of a state agency decision granting a CON to its competitor to construct a 200-bed nursing home. The nursing home application was filed in 1982 and deemed complete in January 1983. At the time, the bed need figures in the "Inventory of Health Care Facilities and Need Determination by Planning Area", a document appended to but not formally adopted as a part of the state agency regulations, showed a need for 291 beds in the area. The Inventory contained population and facility supply data and bed need figures derived by applying need formulae promulgated in the regulations to the data. In June 1983, while the application was undergoing review, the bed need figure shown in the Inventory was reduced to 5 beds following a change in the population data base used to calculate bed need from countywide to township census data. State agency regulations provided that if bed need figures changed during a review because of inventory updating, the figures indicating the largest additional bed need would be used as the standard for review. (Ill. Admin. Reg. §3B.04 C.04). The application was approved in August 1983.

The Court upheld the state agency decision, holding among other things that the Inventory was not a rule requiring formal adoption as a regulation under the state APA before it could be utilized as a standard of review. The state APA only required formal adoption of agency statements of general applicability that implement, apply, interpret, or prescribe law or policy. The Inventory was not such a statement of general applicability but merely a statistic showing bed need figures derived by applying formulae contained in regulations to population and facility supply data.

(8) Cf. Turro v. Dept. of Health and Rehabilitative Services 458 So.2d 345 (Fla. Dist. Ct. App. 1984), infra p. 198.

2. Changes in Criteria and Statistical Data While Applications Are Pending

a. Merry Heart Nursing and Convalescent Home, Inc. v. Dougherty 330 A.2d 370 (N.J.Super.App.Div. 1974)

A nursing home brought an action seeking judicial review of a state CON appeals board decision on its application for a CON to add beds to its facility. The board remanded the application to a state agency hearing officer with directions that the need for the project be reviewed for conformity with the State Plan for Health Care Services as updated shortly after the nursing home's CON application was filed. The Plan was first adopted and promulgated as a regulation on March 9, 1972. It was updated on June 29, 1972, by the addition of statistical data which had the effect of erasing the need indicated in the Plan for plaintiff's project. The update was not promulgated as a regulation. Plaintiff's application had been filed on March 21, 1972. The Court upheld the board's decision, holding that the project should be reviewed for conformity with the updated Plan because it would not deny the applicant due process of law to use the updated information in passing on its application because: (a) the current statistical data was available for inspection, and (b) plaintiff could test the reliability of the information at the hearing through cross-examination and could introduce its own statistics.

b. Cooper River Convalescent Center, Inc. v. Dougherty 336 A.2d 35 (N.J.Super.App.Div. 1975)

A nursing home brought an action appealing the denial of its applications for a CON to add SNF and/or ICF beds to its facility. The application was filed on July 26, 1972. On June 7, 1973, the state agency adopted a moratorium on the issuance of CONs for projects such as plaintiff's. The state agency applied the moratorium in denying plaintiff's application. At the time the court heard the case, the moratorium had been lifted. The Court upheld the moratorium and held that: (1) the moratorium was properly applied to the application, notwithstanding the fact that the application was filed before the moratorium was adopted, because (citing Merry Heart Nursing and Convalescent Home v. Dougherty) viewing an application in light of the facts existing at the time the application is considered serves the legislative intent of the statute better than does viewing the application in light of the facts existing at the time the application is filed, and (2) the proper procedure for reviewing plaintiff's application now that the moratorium has been lifted is to review it before all applications filed after it, not to require applicant to refile and be placed at the end of the line. The imposition of the moratorium gave the agency authority to refuse to issue a CON to the plaintiff, not to deny the application, and thus applications filed during the moratorium are pending.

c. Irvington General Hospital v. Dept. of Health 374 A.2d 49 (N.J.Super.App.Div. 1977)

A hospital brought an action appealing the denial of its application for a certificate of need to add med/surg and intensive care beds to its facility. The application had been recommended for approval by a state agency hearing officer who found a need for the project on the basis of the most recent Department of Health bed need statistics. Between the hearing and the consideration of the project by the Health Care Administration Board (the final CON decision-maker) the Department granted the application of another hospital, Clara Maas Hospital, to reclassify its LTC beds as med/surg beds. The Department then updated its bed need statistics to reflect the reclassification. This had the effect of erasing the need for applicant's med/surg beds. The Board then remanded the application to the hearing officer, who reversed himself and recommended denial solely on the basis of the updated bed need figures. The Board then accepted the hearing office's recommendation. (1) The Court first held that the hearing officer acted properly in considering the updated statistics at the time of the remand hearing, citing Merry Heart Nursing and Convalescent Home v. Dougherty. (2) The Court then reversed the Board decision on the grounds that the Board had erred in relying solely on the bed need statistics in evaluating the application and in neglecting to consider the other statutory criteria. (3) Then, in a holding contradicting that noted at (1) above, the Court remanded and held that if Irvington's application had been filed before Clara

Maas', then Irvington's application should be considered on remand as if Clara Maas' application had not yet been determined, citing Cooper River Convalescent Center, Inc. v. Dougherty. [The Court was apparently unsuccessfully groping for a solution to the problem created by the fact that Irvington and Clara Maas should have had their applications comparatively reviewed from the start since they were competing to satisfy the same need - Ed.]

d. St. Vincent's Hospital v. Finley 380 A.2d 1158 (N.J.Super.App.Div. 1977)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to construct a replacement hospital. For reasons not relevant here the Court remanded the case to the state agency. When the state agency had initially reviewed the application it had, at least at times, taken the position that need was not at issue because a regulation in effect during the earlier stages of review provided that need was not a factor in replacement projects. Additionally, at the time of the initial review the hospital had not presented evidence concerning certain merger prospects because the state agency had advised it that the merger would not be an issue in the consideration of its application. The Court observed that the state statute required evaluation of applications with reference to both need and merger possibilities and that the regulation suspending need review of replacement projects had been repealed. Therefore, the Court held that on remand both the state and the hospital should have the opportunity to supplement the record with respect to these issues because it would be inappropriate to require the state to evaluate the application on remand without reference to such criteria and equally inappropriate to permit the state agency to utilize the criteria without giving the hospital the opportunity to present evidence and argument bearing on them.

e. Saint Joseph's Hospital and Medical Center v. Finley 379 A.2d 467 (N.J.Super.App.Div. 1977)

A hospital brought an action seeking judicial review of the decision of the state agency denying its application for a CON to establish a cardiac surgery program. At the time the hospital's application was filed the state agency had not adopted criteria and standards governing cardiac surgery programs. The application was apparently disapproved on the basis of evidence of under-utilization of existing programs in the area, failure of the applicant to consult with other area hospitals, and because the agency did not want to approve any cardiac surgery programs until it had developed review standards and a carefully organized regional plan for cardiac surgery units. During the pendency of this court appeal the state agency adopted criteria and standards for cardiac surgery programs. The Court upheld the state agency decision, finding that the state's denial of the application was supported by substantial evidence. It then indicated in dicta that: (1) if the hospital were to now reapply for a CON the state agency should apply the new cardiac surgery criteria and standards to it, and (2) even if the state had improperly denied the application [which presumably would have resulted in a remand to the agency by the Court - Ed.] it would still apply the new criteria because: (a) administrative agencies have the authority to modify their regulatory policy; and (b) although an agency must consider the effect of the modification on parties who have justifiably changed their position in reliance on prior agency determinations, no such prejudicial reliance estopping the agency from modifying the regulations was shown in this case. [Compare Irvington General Hospital v. Department of Health supra on the question of the law applicable on remand.]

f. Cf. Health Resources Foundation v. Dept. of Health 377 N.E.2d 1056 (Ill.App. 1978)

A hospital brought an action seeking, in relevant part, judicial review of the decision of the Department of Health denying it a license to establish a new hospital. When the hospital applied for a license state regulations required that applicants finance at least 40% of their new construction costs from "unborrowed equity." The hospital narrowly missed meeting the requirement and, following administrative denial of its application, brought this action. While the suit was pending before the trial court the regulatory requirement was reduced to 20%. The Court held that the 20% requirement should now be applied because the nature and extent of the regulatory change suggested that the Department of Health knew of the change while the application was pending before it and the substantiality of the change coupled with the failure of the Department to give reasons for the change cast some doubt on the validity of the earlier 40% requirement.

g. Hamptons Hospital and Medical Center v. Moore 417 N.W.2d 533 (N.Y. 1981)

A hospital brought an action to enjoin the state agency from reconsidering its prior determination regarding the hospital's application for a CON to construct a new hospital. In 1972 the Public Health Council had passed a resolution proposing to approve the application subject to certain financing conditions. The applicant never secured proper financing. In 1976 the state re-reviewed the need for all pending hospital projects including plaintiff's using a substantially different methodology than had been employed in 1972 when the initial determination of need was made. Concluding that the project was no longer needed, in 1977 the Council proposed to disapprove. The Court refused to enjoin the state agency, holding that the 1972 resolution was merely a tentative proposal to approve subject to reconsideration at any time. It then indicated that: (1) given the Council's obligation to give final approval to only those projects found to be needed, a re-evaluation of need for the project was in order because considerable time had elapsed since the initial determination of need, and (2) the applicant was not entitled to prevent re-evaluation of need on the basis of application of the doctrine of equitable estoppel.

h. Heritage Regency, Inc. v. State Board of Health of Indiana as the Designated Planning Agency No. C-80-9441-C (Indiana Cir.Ct. Wayne County May 21, 1981)

A hospital brought an action seeking judicial review of a DPA decision making findings recommending denial of reimbursement under Section 1122 for a "comprehensive care" (nursing care) facility. The DPA initially disapproved the hospital's application administratively; thereafter a fair hearing officer upheld the initial determination. The DPA used the 1979 Guide to Hospital and Health Facility Bed Need (a state document containing population projections, occupancy figures, and need formulae) in denying the application administratively. At that time the 1980 Guide was available but had not yet been completely tabulated nor approved by the DPA. The 1980 Guide had been approved by the time of the fair hearing and the hearing officer resorted to it to determine need. The Court struck down the DPA decision, holding among other things that there was insufficient evidence to show that the DPA erred in using the 1979 Guide because the 1980 Guide had not yet been properly developed and adopted.

i. Anderson v. Blum 436 N.Y.S.2d 378 (App.Div. 1981)

An adult home brought an action seeking judicial review of the decision of the Commissioner of the State Department of Social Services denying its application for an approval of an expansion of its facility. At the time the application was filed the Commissioner's regulations did not require proof of public need as a criterion for approval but while the application was pending such a regulation was adopted and the application was denied for lack of public need. The Court upheld the Commissioner's decision, holding that the regulation was not improperly applied retroactively to the adult home because the adult home did not, by having applied before the effective date of the regulation, acquire a vested right in expansion approval.

j. Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission No. 80-200439-AA (Mich.Cir.Ct.

Oakland County March 27, 1981), aff'd on other grounds, 312 N.W. 2d 422 (Mich.App. 1981)

A corporation formed to build a new hospital brought an action seeking judicial review of a SHPDA denial of its application for a CON to construct a new hospital. The SHPDA denial was based in part on a need formula contained in the State Health Plan to which population projections also contained in the SHP were applied. Population projections more recent and more accurate than those in the SHP were available but were not used by the state agency. In addition, the state agency included in its inventory of beds in the service area where the proposed hospital would be built 200 beds located in a portion the service area which the agency knew would be split off from the rest of the service area in the next SHP. The Court struck down the state agency decision, holding among other things that the state agency erred: (1) in refusing to consider the evidence of updated population projections, and (2) in considering the 200 beds to be split off, because the agency had the obligation to consider changes in the SHP it knew would occur.

k. Cf. Roskey v. Texas Health Facilities Commission 630 S.W.2d 844 (Tex.Civ.App. 1982)

A taxpayer's association brought an action seeking a declaratory judgement that a CON exemption certificate issued to a district hospital was invalid. The application for the exemption certificate was filed on April 25, 1979 and approved on July 26, 1979. Between those dates, on May 17, 1979, a statutory amendment became effective repealing the sole ground on which the exemption certificate was issued.

The Court dismissed the action. It first concluded that the Commission lacked statutory authority to issue the exemption certificate because: (1) the amending statute contained no saving clause in favor of pending applications and the hospital district had not acquired a vested right immune from the retroactive application of the statute because the Commission had not yet acted when the amending statute became effective; and (2) the amending statute could not be construed not to apply the pending applications through administrative agency "interpretation" or testimony of the sponsoring legislator as to the legislative intent because the statute was unambiguous and required no extrinsic interpretive aid. However, the Court then held that the plaintiffs were not entitled to bring the action.

l. Manor Healthcare Corp. v. Northwest Community Hospital 472 N.E.2d 492 (Ill. App. 1984)

A competitor brought an action seeking judicial review of a state agency decision granting a CON to its competitor to construct a 200-bed nursing home. The nursing home application was filed in 1982 and deemed complete in January 1983. At the time, the bed need figures in the "Inventory of Health Care Facilities and Need Determination by Planning Area", a document appended to but not formally adopted as a part of the state agency regulations, showed a need for 291 beds in the area. The Inventory contained population and facility supply data and bed need figures derived by applying need formulae promulgated in the regulations to the data. In June 1983, while the application was undergoing review, the bed need figure shown in the Inventory was reduced to 5 beds following a change in the population data base used to calculate bed need from countywide to township census data. State agency regulations provided that if bed need figures changed during a review because of inventory updating, the figures indicating the largest additional bed need would be used as the standard for review. (Ill. Admin. Reg. §3B.04.C.04). The application was approved in August 1983.

The Court upheld the state agency decision, holding that the agency did not err in finding a need for the proposed beds and approving the application on that basis because Section 3B.04.C.04 furthered the purpose of the state health planning act to establish an orderly and comprehensive health care delivery system that guaranteed availability of quality health care to the public. 3B.04.C.04 was not arbitrary and capricious since it encouraged applicants to invest the necessary monies to plan a facility and prepare a CON application, while an applicant might be deterred from filing an application if the need figures were subject to constant change during the review period; promoted timely and consistent review since reviewing agencies' recommendations would differ greatly if bed need figures changed during review and the agencies did not all use the same data; and insured that all applicants were given the same consideration since under the regulation an applicant would not suffer because the state issued a CON to parties whose applications were deemed complete on the same date as his, or thereafter.

m. Turro v. Dept. of Health and Rehabilitative Services
458 So.2d 345 (Fla. Dist. Ct. App. 1984)

A hospital brought an action seeking judicial review of state agency decision denying its application for a certificate of need. The application was initially denied for lack of community need as measured by a state agency need methodology which had not yet been formally promulgated as a regulation. During the course of administrative hearings on the application the need methodology was formally adopted and became effective as a regulation. The state agency's final decision to deny was based on lack of need as measured by the methodology. The Court held that the agency did not err in applying the need methodology as adopted by regulation during the pendency of the review proceeding because the methodology prescribed an evidentiary standard and was therefore procedural in nature and became applicable and controlling on its effective date. The Court observed that the application of a newly enacted rule to proceedings which have commenced prior to the rule's effective date could raise due process issues if the rule stated a novel requirement with respect to which a party had not been given an opportunity to conform its proof. However, the Court found no such basis for challenge in this case because the need methodology was merely a formal promulgation of the state agency's asserted position on proof throughout the proceedings and the fact that the applicant sought to demonstrate need by utilizing a variant form of the methodology (which consisted of applying the state's need formula to a subarea instead of the entire health service area) showed that the applicant was aware of the impending adoption and had an opportunity to conform its proofs to the methodology while preparing its case in support of its application.

3. Agency Authority to Omit, Vary, or Give Differing Weights to the Criteria

a. Irvington General Hospital v. Dept. of Health 374 A.2d 49 (N.J. Super.App.Div. 1977)

A hospital brought an action appealing the denial of its application for a CON to add med/surg and intensive care beds to its facility. The state agency denied the application solely on the ground that Department of Health statistics showed an excess of beds in the county in which the facility was located. The state statute set forth several CON criteria and several factors to take into account in determining whether each CON criterion had been met. The Court struck down the agency decision, holding among other things that the state agency erred in considering only the number of beds available in the area because total reliance on bed need statistics would permit decisions which ignored some of the factors the agency was required by law to take into account.

b. Mount Sinai Hospital v. Commission on Hospitals and Health Care No. CV-80-0240625 (Conn. Super. Ct. Hartford-New Britain Jud.Dist. Feb. 27, 1981)

A hospital brought an action seeking judicial review of the decision of the Commission denying its application for a CON to acquire a CT scanner. The CON statute required the Commission to take into consideration a number of matters including the teaching and research expenses of the institution, its community service programs, the need for preservation of capital and segregation of grants, the accounts receivable experience of the applicant, and any other factors the Commission deemed relevant. The Commission's findings accompanying its decision on plaintiff's application stated that the Commission "considered several other criteria which the panel found not relevant to the proposal at hand," and listed the specific criteria described above. The Court remanded, holding that the Commission lacked the legal authority to deem such criteria not relevant because the statute required it to consider such criteria. The failure of the Commission to demonstrate any meaningful consideration of the criteria in the record was therefore an error and the Court remanded the case to the Commission.

c. *Statewide Health Coordinating Council v. General Hospitals of Humana, Inc.* 660 S.W.2d 906 (Ark. 1983)

Competitors and project opponents brought an action seeking judicial review of a state agency decision granting a CON to Humana to construct a new hospital. The Court reversed the SHPDA approval, holding that there was no substantial evidence to support the decision because: (1) the State Health Plan's need formula authorized a four bed per 1,000 bed/population ratio with specified exceptions and the SHPDA regulations stated that each state agency decision to issue a CON must be consistent with the SHP, except in emergency circumstances which pose an imminent threat to public health; (2) the addition of the proposed hospital would cause the bed/population ratio in the health service area to exceed the SHP standard, contrary to the principal goals and objectives of the entire federal and state health planning program to reduce the costs of hospital care by prohibiting the construction of new hospitals that would exceed the limit of four beds per 1,000 population; and (3) if, as Humana contended, the federal and state laws were mere guidelines which the director of the State Agency was free to disregard, then the entire federal and state effort to confine the number of hospital beds to the target limitation would be futile, for every agency director would be free to ignore the limitation whenever he saw fit to do so.

d. *Mercy Health Center v. State Health Facilities Council* 360 N.W.2d 808 (Iowa 1985), *rev'g* No. 44313 (Iowa District Ct., Dubuque County, Jan. 4, 1984).

A hospital brought an action seeking judicial review of a state health facilities council (SHFC) decision denying its application for a CON to convert its acute care facility into an "elder care center." The project involved, among other things, establishment of a new SNF unit and renovation of space to residential apartment, mini-shopping mall, and other non-medical uses. The SHFC denied the application on the grounds of oversupply of SNF beds in the community and because its financing arrangement would result in cross-subsidization (i.e., revenues from health care services would contribute to non-health care services which could be provided by non-health care industries).

The Court upheld the state agency decision, holding that the SHFC's consideration of cross-subsidization was not a misapplication of the statutory criteria or an application of an unpromulgated rule because: (1) The statutory CON criteria are not exclusive in the sense of prohibiting the SHFC from considering matters not specifically enumerated in the statutory list of criteria, although the SHFC must consider the statutory criteria; (2) the SHFC's consideration of cross-subsidization was not the application of an unpromulgated rule, but rather an authorized application of the statutory criteria requiring consideration of immediate and long-term financial feasibility, probable impact on health service costs and charges, and availability of less costly, more efficient alternatives since cross-subsidization is a factual matter which bears directly on these considerations. Finally, the Court held that the SHFC's decision was supported by substantial evidence, observing that the case turned on the cardinal rule of administrative law that judgment calls are the province of the administrative tribunal and not of the courts.

e. Department of Health and Rehabilitative Services v. Johnson and Johnson Home Health Care, Inc. 447 So.2d 361 (Fla.Dist.Ct.App. 1984)

A home health agency brought an action seeking judicial review of a state agency decision denying its application for a CON to establish a new HHA. The state CON statute required the state agency to review CON applications in context with a set of review criteria including need, quality, financial feasibility, accessibility and the like. State agency rules prescribed a threshold requirement for issuance of a CON for new home health services that each existing provider within the service area achieve an average daily census of 300 patients for the immediately preceding calendar quarter. Two exceptions to this requirement were provided when existing agencies were unable to provide service to all persons in need or when the proposed new agency would foster cost containment for all providers. The Court struck down the agency decision, holding that the rule was in excess of delegated legislative authority because it precluded a balanced consideration of all the statutory criteria and allowed the state agency to ignore some statutory criteria and emphasize others.

f. Starks v. Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board 684 S.W.2d 5 (Ky.Ct.App. 1984)

An area resident brought an action seeking judicial review of a state agency decision granting a CON to an applicant to acquire and replace a hospital. The state statutory and regulatory CON review criteria stated that proposals "should" comply with their substantive standards. The Court upheld the state agency decision, holding that the prevalence of the word "should" in the statute and regulations placed broad discretion in the state agency to approve applications notwithstanding some variance with the criteria, and that the applicant met its burden of proof on all issues by substantial evidence.

g. Princeton Community Hosp. v. State Health Planning 328 S.E.2d 164 (W.Va. 1985)

Two hospitals brought consolidated actions seeking judicial review of state agency decisions denying their applications for bed addition/expansion CONs. The state CON statute contained a set of community need and other CON review criteria resembling the NHPRDA review considerations (42 U.S.C.A. §300n-1(c); Public Health Service Act §1532(c)) and a separate provision requiring that a CON issue only if consistent with the SHP. The SHP contained an acute bed need formula. The state agency denied the applications solely on the basis of inconsistency with the SHP bed need formula.

The Court upheld the state agency's denial of the hospitals' applications, holding that under the state CON statute a project inconsistent with the SHP was required to be denied and, citing Statewide Health Coordinating Council v. General Hospitals of Humana, Inc., supra., a determination of inconsistency with the SHP could not be counterbalanced by a favorable finding with respect to other criteria or aspects of the proposal. It rejected the hospitals' argument that denial of a CON based solely on a statistical bed need formula was arbitrary and capricious, holding that the court decisions cited by the hospitals in support of their argument (Sturman v. Ingraham, Irvington General Hospital v. Dept. of Health, and Fairfield Nursing Home v. Whalen) were inapposite because they did not address the bed need issue within the context of a statutory mandate of SHP consistency. The Court also held that the SHP provisions labeled "Recommended Actions" were in fact requirements, not mere recommendations, because the SHP clearly provided that the recommended actions were chosen to implement SHP objectives and the recommended actions were intended to lend flexibility to the Plan's objectives.

4. Statutory Requirement That Agency "Consider" the Criteria

a. West Virginia Health Systems Agency, Inc. v. State Health Planning and Development Agency Civ. No. AP-CA-80-1 (W.Va.Cir.Ct. Kanawha County July 2, 1980)

An HSA brought an action seeking judicial review of a state agency decision granting a CON for construction of a replacement hospital. The HSA alleged that the state agency erred in approving the application because the proposed project was not in compliance with the HSP objectives relating to quality of care. The state statutory criteria required the state to "consider" the various criteria in making its determination as to whether a certificate of need should be issued including considering "the relationship of the health services being reviewed to the applicable health systems plan and annual implementation plan adopted by the designated health systems agency...". In upholding the SHPDA decision the Court held that rigid compliance with each objective of the HSP or with each criterion of the CON statute and regulations was not required. Substantial evidence in the record as a whole indicating substantial compliance with the HSP was sufficient grounds for upholding the SHPDA decision because the statutory language looked to the relationship with the plan as a whole, not to compliance with each part of the plan.

b. Mercy Health Center v. State Health Facilities Council 360 N.W.2d 808 (Iowa 1985), rev'g No. 44313 (Iowa District Ct., Dubuque County, Jan. 4, 1984).

A hospital brought an action seeking judicial review of a state health facilities council (SHFC) decision denying its application for a CON to convert its acute care facility into an "elder care center." The project involved, among other things, establishment of a new SNF unit and renovation of space to residential apartment, mini-shopping mall, and other non-medical uses. The SHFC denied the application on the grounds of oversupply of SNF beds in the community and because its financing arrangement would result in cross-subsidization (i.e., revenues from health care services would contribute to non-health care services which could be provided by non-health care industries).

The Court upheld the state agency decision, holding among other things that the SHFC's consideration of cross-subsidization was not a misapplication of the statutory criteria or an application of an unpromulgated rule because: (1) the statutory CON criteria are not exclusive in the sense of prohibiting the SHFC from considering matters not specifically enumerated in the statutory list of criteria, although the SHFC must consider the statutory criteria; (2) the SHFC's consideration of cross-subsidization was not the application of an unpromulgated rule, but rather an authorized application of the statutory criteria requiring consideration of immediate and long-term financial feasibility, probable impact on health service costs and charges, and availability of less costly, more efficient alternatives since cross-subsidization is a factual matter which bears directly on these considerations. Finally, the

Court held that the SHFC's decision was supported by substantial evidence, observing that the case turned on the cardinal rule of administrative law that judgment calls are the province of the administrative tribunal and not of the courts.

5. Cases Dealing With Specific Types of Criteria.

a. The "Need" Criterion

(1) The validity and use of moratoriums on new CONs

(A) Cooper River Convalescent Center, Inc. v. Dougherty 336 A.2d 35 (N.J.Super.App.Div. 1975)

A nursing home brought an action appealing the denial of its application for a CON to add SNF and/or ICF beds to its facility. The application was filed on July 26, 1972. On June 7, 1973, the state agency adopted a moratorium on issuance of CONs for projects to add new SNF beds and on August 31, 1973, it extended the moratorium to cover ICF beds. The application was apparently denied at least in part on the basis of the moratorium. At the time the Court heard the case (1975) the moratorium had been lifted. The Court upheld the state agency decision, making the following rulings. (1) The state agency had the authority to adopt the moratorium because: (a) the state CON statute, which authorized the state agency to take actions to implement the public policy that "hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health," should be liberally construed to enable the agency to achieve the task assigned to it and the courts should imply, where necessary, incidental powers necessary to achieve the legislative scheme; and (b) the moratorium furthered the legislative objective of properly utilizing health care services. During the period of June 7, 1973 - Aug. 31, 1973, the moratorium applied only to SNF beds in order to encourage conversion of SNF beds to ICF beds and thereby remedy the excess of SNF beds and deficiency of ICF beds indicated in the State Health Plan. The Court indicated that this selective moratorium technique was a rational planning approach. (2) It was proper for the agency to apply the moratorium to the plaintiff's application even though the moratorium had been adopted after the application was filed. (3) The proper procedure for reviewing plaintiff's application now that the moratorium has been lifted is to review it before all applications filed after it, not to require plaintiff to refile and be placed at the end of the line. The moratorium gave the agency the authority to refuse to issue a CON to the plaintiff, not to deny the application, and thus applications filed during the moratorium are pending.

(B) Wisconsin Hospital Association v. State Dept. of Health, et al. No. 82-CV-2653 (Wisc.Cir.Ct., Dane Cty., Mar. 8, 1983)

A hospital association brought an action seeking a declaratory judgement that the state's statutory CON moratorium conflicted with NHPRDA and thus was unconstitutional under the Supremacy Clause; and that the informal procedures used by the SHPDA to administer the moratorium were invalid because not formally promulgated as regulations.

The Court granted summary judgement for the SHPDA, ruling that the moratorium did not violate the Supremacy Clause by conflicting with NHPRDA because: (1) NHPRDA is not compulsory on the state and a state is not obliged to conform its health policy laws and regulations to NHPRDA; and (2) as a consequence, the differences between Wisconsin's law and the federal law are not important for purposes of determining whether Wisconsin's moratorium unconstitutionally conflicts with federal law. The court stated, "If the state agency, which is obliged to carry out the directives of the state legislature and administer the moratorium, fails to meet the federal criteria for a CON program, then the Secretary of the federal Health and Human Services agency may act to reduce and finally eliminate grants to the state agency under 42 U.S.C. $300m(d)(2). But that is the extent of the penalties that may be imposed. The Secretary may not compel Wisconsin to adopt a CON program that meets federal guidelines. It is for the federal agency to determine whether the Wisconsin agency will continue. The federal agency has so far declined to determine that Wisconsin is not in compliance, and this Court cannot determine otherwise."

The Court also ruled that the "Procedures for Moratorium Implementation," a SHPDA document containing guidelines for calculating coverage and exemptions from the moratorium, was an agency statement of general policy required to be promulgated by regulation. However, the Court refused to order the SHPDA to accept and process all CON applications, regardless of whether they were covered by the moratorium, until such time as regulations were adopted because the legislature did not require promulgation of rules in order to interpret and implement the statute and the statutory provision for the moratorium was clear and self-executing.

(C) Balsam v. Dept. of Health and Rehabilitative Services 452 So.2d 976 (Fla. Dist.Ct.App. 1984)

Proponents of a psychiatric hospital construction project brought an action challenging the validity of a SHPDA moratorium on CON reviews and apparently seeking an order compelling the SHPDA to review their CON application in a particular batching cycle. At the time plaintiffs filed their application the SHPDA had administratively imposed a time-limited moratorium on CON reviews for the stated purpose of allowing it time to promulgate rules on statewide bed-need methodologies required by recent legislation. The SHPDA informed plaintiff that it could re-file an application to be processed in the first post-moratorium batching cycle. The state CON statute required the SHPDA to review CON applications in no less than four batched reviews per year and the SHPDA had adopted batching cycle regulations. The Court held that: (1) the controversy was not moot on the grounds that the moratorium had expired, nor did plaintiffs lack standing to challenge the moratorium on the grounds that they had not lost any competitive advantage, because imposition of the moratorium affected their substantial interests; and (2) the moratorium was an agency rule, invalid since not formally adopted as a regulation, because it was a statement of general applicability consistently applied to all applications during the time it was in force. The Court rejected the argument that the moratorium was not a rule because it had a stated finite duration. The Court also rejected the argument that the moratorium could best be characterized not as a rule but as a temporary suspension or deviation from the batching cycle regulations, noting that there were no provisions in the regulations which would allow suspension of a current rule or deviation from a promulgated rule and such suspension would be in direct contravention of the statutory requirement of review no less than four times per year.

(D) United Hospital Center, Inc. v. Richardson 328 S.E.2d 195 (W. VA. 1985)

A hospital brought an action in mandamus seeking to compel a state agency to process its application for a CON to acquire a MRI unit. After the hospital's application was filed the state agency imposed an administrative moratorium on the acceptance and determination of completeness of CON applications for MRI, relying as authority for the moratorium on a statutory provision commanding it to take actions in the exercise of its CON and other functions to allocate the supply of health services not appropriately allocated by competition. The immediate purpose of the moratorium was to gain sufficient time to develop MRI review criteria. On the basis of the moratorium the state agency declined to determine the completeness of the hospital's application or to further process it. The state CON statute required the state agency to determine whether an application was complete within 15 days of receipt, and generally required 90-day review after determination of completeness. The court granted the hospital's petition and ordered the state agency to determine whether or not the application was complete, holding that: (1) the general authorization to allocate supply did not authorize the state agency to ignore the 15-day completeness determination requirement; and (2) the moratorium imposition was arbitrary and capricious because it was unnecessary since existing statutes and regulations (which permitted the agency to adopt criteria for determining when 90-day review would be impracticable, to adopt varying CON review regulations for different health services, and to use national or commonly-accepted review standards when local or state standards were unavailable) allowed an opportunity for the development of MRI standards during the agency's regular review process.

(2) The validity and use of numerical formulas and statistical data to determine need for new health services

(A) Need formula as exclusive CON criterion/need measure

(i) Sturman v. Ingraham 383 N.Y.S.2d 60 (App.Div. 1976)

A nursing home operator brought an action seeking judicial review of the state agency's decision denying her application for approval of an expansion project. The application was denied on the basis of lack of need as indicated in a state agency document which identified the need for long-term care beds in each county in the state and provided that since ninety-five percent of the need in Westchester County (where plaintiff's facility was located) was satisfied no further approvals were indicated. The Court reversed the state agency decision, ruling in an alternate holding the Court that the state agency erred in denying the application on the basis of a preset, rigid numerical policy (not contained in the statute) which foredoomed the application because that procedure precluded a fair review of the unique, individual facts and merits of the application. The Court remanded to the state agency for a rehearing.

(ii) Irvington General Hospital v. Dept. of Health 374 A.2d 49 (N.J.Super.App.Div. 1977)

A hospital brought an action appealing the denial of its application for a CON to add med/surg and intensive care beds to its facility. The state agency denied the application solely on the ground that Department of Health statistics showed an excess of beds in the county in which the facility was located. The state statute set forth several CON criteria and several factors to take into account in determining whether each criterion had been met. The Court struck down the state agency decision, holding among other things that the state agency erred in considering only the number of beds available in the area because total reliance on bed need statistics would permit decisions which ignored some of the factors the agency was required by law to take into account.

(iii) Fairfield Nursing Home v. Whalen 407 N.Y.S.2d 923 (App.Div. 1978)

A nursing home brought an action seeking judicial review of a decision of the state agency denying its application for a CON to expand its facilities. The state agency denied the application on the basis of lack of need as measured by a numerical formula, the "Hill-Burton formula," used to project needed facilities in the county. Following Sturman v. Ingraham, the Court struck down the state agency decision, holding that the state agency erred in denying the application on the basis of only one factor, the statistical county-wide "need" formula, because doing so foreclosed consideration of other relevant factors including factors identified by the state agency in its review guidelines such as the extent of waiting lists for admission to existing facilities in the service area, any difficulty the local social services office had in placing patients, and delay in discharging patients from hospitals because of nursing home bed shortages.

(iv) Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission No. 80-200439-AA (Mich.Cir.Ct. Oakland County March 27, 1981), aff'd on other grounds, 312 N.W. 2d 422 (Mich.App. 1981)

A hospital corporation brought an action seeking judicial review of a SHPDA denial of its application for a CON to construct a new hospital. The state CON statute contained several review criteria, including consistency with the State Health Plan. The only one of these criteria used by the SHPDA in denying the hospital's application was the need formula embodied in the SHP. The Court struck down the state agency decision, holding among other things that where the SHPDA preclusively relied on a mathematical determination of overbeddedness it was imperative that the agency be willing to consider evidence of errors in the data used in applying the formula. The Court held that the state agency erred in applying the need formula by refusing to consider new data updating the population projections contained in the SHP.

(v) Cf. Anderson v. Blum 436 N.Y.S.2d 378 (App.Div. 1981)

An adult home brought an action seeking judicial review of the decision of the Commissioner of the State Department of Social Services denying its application for approval of a project to expand its facility. The adult home argued that the state had improperly applied a rigid numerical geographical standard in assessing public need and that the denial should therefore be reversed on the authority of Fairfield Nursing Home v. Whalen and Sturman v. Ingraham. The Court upheld the Commissioner's decision, holding that an examination of the record of the administrative proceedings below made it clear that the agency considered other relevant factors in reaching its determination and consequently Fairfield and Sturman were inapposite.

(vi) Martin County Nursing Center v. Medco Centers, Inc. 441 N.E.2d 964 (Ind. App. 1982)

A nursing home brought an action seeking to reinstate a DPA hearing officer's decision making findings recommending approval under Section 1122 of its project to construct a new 60 bed nursing home. The nursing home (Martin) had filed an 1122 application competing with that of Medco (the existing facility in the area which proposed a replacement/expansion project). The State Health Plan projected a bed need in the area which the Medco project would satisfy and which the Martin project would exceed. A witness at the fair hearing testified that notwithstanding the Plan projection there was an areawide need for the number of beds which the Martin project proposed. The hearing officer relied upon this testimony, among other things, in ruling in favor of Martin and against Medco. With respect to the need criterion the trial court which heard Medco's petition for judicial review relied exclusively on the Plan and ruled against Martin.

The Court of Appeals reversed and upheld the hearing officer's decision approving Martin, holding that: (1) there was substantial evidence to support the hearing officer's decision on need, because the DPA's bed need projection formula was not conclusive proof of need but merely some evidence of need, and the hearing officer was not constrained by the formula to determine the particular need for the local area; and (2) the trial court exceeded the proper scope of review of the hearing officer's decision under the substantial evidence test by reweighing the evidence.

(vii) Mid-Ohio Health Planning Federation v. Certificate of Need Review Board No. 81AP-958 (Ohio.Ct.App. Franklin County, April 1, 1982)

An HSA brought an action seeking judicial review of a SHPDA decision, affirmed on administrative appeal by the state CON Review Board, that a CON be awarded for a hospital replacement/relocation project.

The Court upheld the SHPDA decision, making a number of rulings on procedural and substantive issues. It held that the granting of the CON was not inconsistent with a state regulation which provided that a hospital "must meet the bed to population ratio [4 beds per 1,000 population] set forth in the national guidelines for health planning, 42 CFR Part 121., as set forth in the Ohio State health plan", even though the approval resulted in a 19 bed excess under the ratio, because: (1) even though the rule itself appears to be stated in mandatory terms, the bed need formula alone is not determinative and the CON review process is to be conducted by evaluating many factors and in some instances some factors will support and others mitigate against issuance (*citing* *Irvington General Hospital v. Department of Health* and *Sturman v. Ingraham*); and (2) the 4 beds per 1,000 formula, as it appears in the SHP, is captioned as a recommended action rather than an absolute bar, although later stated in mandatory terms. [*Compare* *Princeton Community*, *infra*.]

(viii) *Northwest Health Care, Inc. v. Idaho Health Facilities Review Board* No. 76772 (Idaho Dist.Ct.Ada Cty. Jan. 27, 1983)

A nursing home brought an action seeking judicial review of a state agency decision granting a CON to its competitor, a retirement residence center, to construct a 20 bed nursing home unit in the center. The nursing home alleged among other things that the state violated the purposes of the state CON statute by treating the proposed unit as a unique facility and determining the need for it based on considerations other than absolute necessity, including considering the fact that the nursing home unit would be associated with the retirement center.

The stated purposes of the CON statute were to:

> assist in providing the highest quality care; to avoid unnecessary duplication by insuring that only those new health care facilities, equipment, and institutional services that are needed will be built, modified or offered; to provide an orderly method of resolving questions concerning the necessity for new health care facilities...; and to assure that necessary and adequate health care facilities...are available and accessible to all the people of this state. (Idaho Code §39-4902 (1980))

The Court upheld the state agency decision, holding among other things that it was not improper for the state agency to consider the effects of the retirement center and continuum of care concept when it made judgements about the quality of care in the proposed facility because under the quoted provision (and in the statutory language and legislative history of NHPRDA) the state agency should not limit its need inquiry solely to numbers of beds but should take into account quality, acceptability, and other related matters.

(ix) Department of Health and Rehabilitative Services v. Johnson and Johnson Home Health Care, Inc. 447 So.2d 361 (Fla. Dist. Ct. App. 1984)

A home health agency brought an action seeking judicial review of a state agency decision denying its application for a CON to establish a new HHA. The state CON statute required the state agency to review CON applications in context with a set of review criteria including need, quality, financial feasibility, accessibility and the like. State agency rules prescribed a threshold requirement for issuance of a CON for new home health services that each existing provider within the service area achieve an average daily census of 300 patients for the immediately preceding calendar quarter. Two exceptions to this requirements were provided when existing agencies were unable to provide service to all persons in need or when the proposed new agency would foster cost containment for all providers. The Court struck down the agency decision, holding that the rule was in excess of delegated legislative authority because it precluded a balanced consideration of all the statutory criteria and allowed the state agency to ignore some statutory criteria and emphasize others.

(B) Use of county/official boundaries to define service areas for purposes of applying numerical need formulas.

(i) Cases rejecting use of county/official boundaries.

(a) Woodland Park Hospital, Inc. v. Comprehensive Health Planning Authority 504 P.2d 753 (Ore.App. 1972)

A competitor brought an action appealing the granting of a CON to a Seventh Day Adventist hospital to relocate its facilities in close proximity to the plaintiff's facility. The state statute provided that need should be determined with reference to the "defined population," meaning the population that may reasonably be expected to be served by the proposed hospital. The statute also provided that "defined population" shall not be limited to a geographical area. The state agency determined that the population to be served by the relocated facility would be essentially the same as the population the hospital presently served because the primary factors in choice of hospital are the patient's physician's choice and the patient's religious preference and in this case physicians and patients who now prefer the hospital will continue to do so after its relocation. The Court upheld the state agency's determination of the defined population, rejecting the plaintiff's argument that the state should have given greater weight to geographic considerations.

(b) Irvington General Hospital v. Department of Health 374 A.2d 49 (N.J.Super.App.Div. 1977)

A hospital brought an action appealing the denial of its application for a CON to add med/surg and intensive care beds to its facility. The state statute set forth as one of several CON criteria whether the proposed project, "is necessary to provide required health care in the area to be served." The state agency denied the application solely on the ground that its statistics showed an excess of beds in the county in which the facility was located. The Court struck down the state agency decision, holding among other things that the state agency erred in denying the application solely on the basis of county-wide statistics because while the state is authorized by law to designate areas for health care planning and to keep current statistics thereon it must, if appropriate, recognize and accept a need for special services in any local area smaller than the larger health care area established by the state. The Court found compelling evidence in the record that the proposed beds would actually serve aged patients residing near the facility for whom, due to their infirmity, the inadequacy of public transportation, and their desire to remain close to family and friends, other hospitals in the county were inaccessible or undesirable.

(c) Sturman v. Ingraham 383 N.Y.S.2d 60 (App.Div. 1976)

A nursing home operator brought an action seeking judicial review of the state agency's decision denying her application for approval of an expansion project. The application was denied on the basis of lack of need as indicated in a state agency document which identified the need for long-term care beds in each county in the state and provided that since ninety-five percent of the need in Westchester County (where plaintiff's facility was located) was satisfied no further approvals were indicated. The Court reversed the state agency decision, holding among other things that the state erred in denying on the basis of a rigid, fixed numerical policy. The Court also noted that the use of rigid or artificial geographical segmentations (such as county boundaries) in the need formula can be arbitrary and improper because approval hinges upon which side of a county line an applicant plans his facility.

(d) Fairfield Nursing Home v. Whalen 407 N.Y.S.2d 923 (App.Div. 1978)

A nursing home brought an action seeking judicial review of a decision of the state agency denying its application for a CON to expand its facilities. The state agency denied the application on the basis of lack of need as determined by application of a numerical formula, the "Hill-Burton formula," to demographic and bed-supply data for the county in which the applicant's facility was located. The Court struck down the state agency decision, holding that the state agency erred in using county boundaries to determine need because while the use of such a geographical division may simplify the task of determining need it has no compelling relationship to the ultimate question of need and is arbitrary. A facility located at one end of a county which has no need for additional facilities but in proximity to counties which have extreme unmet need may be rejected despite the necessity for extra facilities in a nearby area.

(ii) Cases upholding use of county/official boundaries.

(a) Cf. Saint Joseph's Hospital and Medical Center v. Finley 379 A.2d 467 (N.J.Super.App.Div. 1977)

A hospital brought an action seeking judicial review of the decision of the state agency denying its application for a CON to establish a cardiac surgery program. The application was disapproved in part because the state agency did not want to approve cardiac surgery programs until it had adopted a carefully organized regional plan for such services pursuant to the statutory CON criteria that the proposed project be necessary to provide required health care "in the area to be served" and that it contribute to the "orderly" development of health care services. In upholding the agency decision as supported by substantial evidence the Court noted that while the hospital offered persuasive arguments that its particular facility appeared to be suited to the establishment of a cardiac surgery unit, the statute required the state agency to consider area needs in issuing CONs for the establishment of health facilities.

(b) Tarpon Springs General Hospital v. Office of Community Medical Facilities 366 So.2d 185 (Fla.Dist.Ct.App. 1979)

A hospital brought an action appealing a state agency decision denying its application for a CON to expand its facilities. The hospital alleged that the denial was based, in part, on the state agency's arbitrary use of county boundaries to define service areas. The hospital was located in overbedded Pinellas County but was within three miles of underbedded Pasco County. The Court upheld the state agency decision, holding that there was evidence in the record showing that the HSA and state agency analyzed the needs of Pasco County before denying plaintiff's application and concluded that although Pasco County had an overall bed deficit the two hospitals in Pasco County were accessible to Pasco County patients residing near the plaintiff's facility.

(c) North Charleston Medical Center, Inc. v. South Carolina Department of Health and Environmental Control No.___ (S.C. County Court Charleston County November 21, 1975), reprinted in HOSPITAL FRANCHISING LAW AND REGULATION (A SOUTH CAROLINA CASEBOOK) 369 (1979)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to construct a new facility. The state statute provided for issuance of CONs to projects that "will meet public needs of the community where the facility is to be located." The new hospital was to be located in a suburban city which had no existing hospital within its boundaries. The applicant alleged that the state agency's refusal to restrict its consideration to the confined geographic area of the city and its insistence on considering the larger metropolitan area was beyond its statutory authority. The Court dismissed the action, holding among other things that the agency had the authority to consider the larger areawide need for services because: (1) the state legitimately concluded that the only means of assuring that community needs can be met is planning on an areawide basis, and (2) the United States Department of Commerce designation of a larger area as a Standard Metropolitan Statistical Area (SMSA) is strong support for the proposition that the city does not stand alone as a separate community.

(d) West Virginia Health Systems Agency, Inc. v. State Health Planning and Development Agency No. AP-CA-80-1 (W.Va.Cir.Ct. Kanawha County July 2, 1980)

An HSA brought an action seeking judicial review of a state agency decision granting a CON for construction of a replacement hospital. The HSA alleged that the SHPDA erred in the method it used in calculating the bed to population ratio in the health service area, which encompassed four counties, and consequently erred in its determination of need for the project. The SHPDA employed a quantitative approach to determining bed need under which need was shown if the bed to population ratio in the area after the project was instituted would not exceed a predetermined number. The formula showed no need in the health service area as a whole. The SHPDA made a number of "adjustments" to the figures for in-migration and out-migration of patients from a two-county area the cumulative effect of which was to apply the formula to a two-county rather than a four-county area. After the adjustments the formula showed a need in the two-county area. The Court held that the SHPDA's adjusted bed to population ratio method for calculating need was based on an acceptable statistical technique and therefore supported by substantial evidence.

(e) In re Certificate of Need Application by Community Psychiatric Centers, Inc. 676 P.2d 107 (Kansas 1984)

Two psychiatric hospital applicants, Excepticon and CPC, brought separate actions seeking judicial review of State Agency (KDHE) denials of their applications to construct new facilities in Johnson County.

The Court upheld KDHE's denials as supported by substantial evidence. KDHE denied both applications for failure to satisfy its review criteria of community need and cost containment. It evaluated the applications on the basis of community need and cost containment impact in a seven-county health service area which included Johnson County and concluded that the new facilities, though more cost-effective than existing facilities, would increase the cost of health care in the existing facilities in the area in which bed space and care was available to the general public. The Court rejected the argument raised by the applicants that the CONs should be approved because there was a need for additional facilities to provide bed space and psychiatric treatment in Johnson County, observing that if this were the test to be applied, then each county included in the seven-county area could show a need for expansion of health care facilities when considered separately from the surrounding area, thereby defeating the legislative requirement of a statewide health program.

(f) Princeton Community Hosp. v. State Health Planning 328 S.E.2d 164 (W.Va. 1985)

Two hospitals brought consolidated actions seeking judicial review of state agency decisions denying their applications for bed addition/expansion CONs. The state CON statute contained a set of community need and other CON review criteria resembling the NHPRDA review considerations (42 U.S.C.A. §300n-1(c); Public Health Service Act §1532(c)) and a separate provision requiring that a CON issue only if consistent with the SHP. The SHP contained an acute bed need formula which measured bed need by projecting existing use rates onto future population estimates and applying the expected rates derived thereby to bed inventory data, with adjustments for acceptable occupancy levels. The service area to which the SHP need formula was applied consisted of the county in which a project was proposed and any adjacent counties whose residence would use the proposed beds at a specified level. In applying the formula the state agency also adjusted for net patient migration into and out of the service area by deducting the excess of area beds used by in-migrating patients over non-area beds used by out-migrating patients from the available area bed inventory. The state agency denied the applications solely on the basis of inconsistency with the SHP, and a trial court reversed the state agency and granted CONs without remanding to the agency.

The Court then upheld the state agency's denial of the hospitals' applications. Among other things, the Court rejected the hospitals' argument that the state agency ignored the need for their particular services by in-migrating patients, noting that: (1) the agency accounted for net patient migration based on an HSA-conducted scientific patient flow study; and (2) although on hospital presented in-migration data more current than that used in the HSA study, the state agency found it unreliable because the hospital presented no comparable out-migration data.

(C) Issues relating to inventories of beds, services, and equipment in defined service areas.

(i) Cf. American International Health Services, Inc. v. Rhode Island Department of Health Nos. 77-3474 and 77-282 (R.I.Super.Ct. Providence County Sept. 11, 1978), cert. den., 396 A.2d 945 (R.I. 1979), app. dism'd., No. 78-355 -Appeal (R.I._____ 1979)

A corporation brought an action seeking judicial review of a state agency decision denying its application for a CON to construct a specialty hospital for detoxification and rehabilitation of patients suffering from the disease of alcoholism. The state agency denied the application on the basis of the statutory CON criteria which required a showing of "public need" for the "construction" and its determination that there was an excess of hospital beds in the state. The applicant argued that the state agency should have considered the public need for alcoholism services and the question whether there were sufficient beds dedicated to alcoholism detoxification and rehabilitation. The Court upheld the state agency, ruling that approval for construction has nothing to do with the services to be rendered at the place where facilities are located.

(ii) Passaic General Hospital v. Finley No. A-3480-78 (N.J. Super.Ct.App.Div. Mar. 27, 1980)

A hospital brought an action appealing the denial of its application for a CON to acquire a CT scanner and the awarding of a CON to a competitor. There was a privately owned CT scanner not covered by the CON statute in the area and the plaintiff had contracted with the owner to acquire the scanner if it received a CON. In reviewing plaintiff's application the state agency did not take the privately owned CT scanner into account in counting the number of scanners needed in the area. The Court upheld the state agency decision, holding that the state agency did not err in refusing to consider the privately owned CT scanner because it had no control over the scanner's owners and could be assured neither that they would discontinue providing scanner services if the plaintiff obtained a CON nor that they would continue providing such services if the agency took the scanner into account in determining number of scanners needed in the area.

(iii) Hospital of St. Raphael v. Commission on Hospitals and Health Care 438 A.2d 103 (Conn. 1980)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to acquire a CT scanner. In determining need the state agency considered a scanner located in Yale-New Haven Hospital (a hospital in the service area) which was not owned by Yale-New Haven but had been loaned to it by the manufacturer and which, although on loan primarily for research purposes, was being used to provide clinical services because Yale-New Haven's regular scanner was not functional. The state agency also considered another scanner which was located in the offices of a radiological group practice and therefore not covered by CON. The Court upheld the state agency decision, ruling that the state agency did not err in considering these CT scanners nor in denying the application for lack of regional need based on the availability of these scanners because there was nothing in the statutory scheme which limited the state agency to a consideration of only such units as are owned by regulated health care facilities. In arriving at its finding of regional need the state may consider all units available for medical use by the general public whether operated by regulated or non-regulated health care facilities. If a unit is on loan for a limited purpose such as research but is in fact also used for clinical purposes, it is for the state to weigh this factor in its deliberations and to determine to what extent, if any, it would discount the availability of such unit because of evidence of limited use.

(iv) Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission No. 80-200439-AA (Mich.Cir.Ct. Oakland County March 27, 1981), aff'd on other grounds, 312 N.W. 2d 422 (Mich.App. 1981)

A hospital corporation brought an action seeking judicial review of a SHPDA denial of its application for a CON to construct a new hospital. The state agency included in the inventory of beds in the service area where the proposed hospital would be built 200 beds located in a portion of the service area which the agency knew would be split off from the rest of the service area in the next state Health Plan. The Court struck down the state agency decision, holding among other things that the state agency erred in considering the 200 beds because the agency had the obligation to consider changes in the SHP it knew would occur.

(v) Heritage Regency, Inc. v. State Board of Health of Indiana as the Designated Planning Agency No. C-80-9441-C (Indiana Cir.Ct. Wayne County May 21, 1981)

A hospital brought an action seeking judicial review of a DPA decision making findings recommending denial of reimbursement under Section 1122 for a "comprehensive care" (nursing care) facility. In calculating need for the project the DPA included in its bed inventory certain comprehensive care beds in the service area which had been approved five years earlier but never constructed. The Court struck down the DPA decision, holding among other things that the state agency erred in failing to consider whether these beds were available and in not concluding that they were in fact unavailable.

(vi) In re Certificate of Need Application by Bethany Medical Center 630 P.2d 1136 (Kan. 1981)

The State Department of Health and Environment brought an action appealing the decision of the Kansas Corporation Commission (the administrative agency which heard administrative appeals from Health Department CON decisions) reversing the Department's decision denying Bethany Hospital's application for a CON to acquire a linear accelerator. The Department's criterion for determining need for linear accelerators, based on a portion of the National Guidelines for Health Planning (42 CFR §121.209(a)(2)), was that no additional units should be added until all existing units in the area were performing 6,000 treatments per year. A university hospital in the area had recently acquired one extra high voltage accelerator and had another on order. If the high energy accelerators were counted need could not be shown. The Department counted them. The Corporation Commission did not, basing its decision on another provision of the National Guidelines (42 CFR §121.209(b)) which provided that "dedicated special purpose and extra high energy machines which have limited but important applications may not perform 6,000 treatments per year and should be evaluated individually by HSAs in the development of Health Systems Plans." The Court upheld the Commission's decision, holding that the Commission's decision was supported by substantial evidence in the record including evidence that high energy machines are not capable of treating as many patients as low energy machines, that high energy machines require more adjustment and more skilled operators and are not appropriate for "run of the mill" patients, and evidence that the University hospital units would not be used for "run of the mill" patients but would be available as back-up units for Bethany hospital patients needing specialized treatment.

(vii) In re Rev. of Dec. of Kansas Corp. Com'n 659 P.2d 199 (Kan. 1983)

A competitor (Bethany Medical Center) brought an action appealing the decision of KCC (the state agency which heard administrative appeals of CON decisions) to grant a CON to Providence-St. Margaret Health Center to acquire a 6MeV linear accelerator. KCC had reversed the SHPDA denial of the application.

At the time of the Providence application there were four linear accelerators in the service area: two low energy units and two extra high energy units, all located at a university hospital. In addition, after the SHPDA decision but prior to the KCC decision the State Supreme Court had affirmed an earlier KCC decision granting Bethany a CON for a low-energy linear accelerator. (In re Certificate of Need Application by Bethany Medical Center, supra.) The state used the linear accelerator need methodology set forth in the National Guidelines for Health Planning (42 C.F.R. §121.209) which among other things provided that: (1) each unit should serve a population of 150K and treat 300 cancer cases annually; (2) no additional units should be approved until all existing general purpose units in the area were performing 6,000 treatments per year; and (3) "dedicated special purpose and extra high-energy machines which have limited but important applications may not perform 6,000 treatments per year and should be evaluated individually by HSAs in the development of HSPs."(42 C.F.R. §121.209(b)).

The SHPDA had "individually evaluated" the extra high-energy machines by treating the two as if they were one machine for purposes of the need formulae (giving the area three or four existing units, depending upon whether Bethany's unit was counted) and apparently had denied on the grounds that the population/unit and cancer cases/unit formulae projected a need for fewer than four units. KCC "individually evaluated" the two machines by excluding them altogether from consideration in applying the need formulae.

Apparently concluding that KCC's jurisdiction was limited to considering whether there was substantial evidence in the record to support the SHPDA's decision, the Court held that KCC erred in overturning the SHPDA decision because in doing so KCC ignored the SHPDA's "individual evaluation" of the two extra high energy units. [Compare the Court's earlier ruling in In re Certificate of Need Application by Bethany Medical Center, supra, which criticized the SHPDA for counting each extra high energy unit individually for purposes of the need formulae as a failure to individually evaluate the units, and upheld a KCC decision which excluded the two units from consideration altogether.]

The Court also held that KCC and the trial court which upheld its decision erred in failing to acknowledge and judicially notice the approval of the Bethany unit by the Supreme Court subsequent to the SHPDA decision because this procedure, which would even more clearly indicate absence of need for a new unit, would have been consistent with state and national health planning statutes indicating the need for consideration of as current information as is feasible and proper.

(viii) Baird v. Axelrod 477 N.Y.S.2d 845 (App. Div. 1984)

A nursing home brought an action seeking judicial review of a state agency decision denying its application to add two beds. The nursing home, which did not participate in Medicaid and did not accept public funds, alleged that the state agency lacked jurisdiction over it and other health care facilities that did not accept public funds; that the denial was unsupported by substantial evidence because, among other things, the state's need formula overstated the service area's bed excess by lumping skilled nursing and "health-related" [e.g., intermediate care and medically-oriented residential care] facilities together; and that the application was wrongfully denied on the basis of Medicaid non-participation. The Court held that: (1) the state had the authority to regulate the nursing home because the state CON statute, which conditioned approval of public and private facility projects on a finding of public need, made no distinction between hospitals that received public funding and those that did not; (2) the state's bed need formula did not improperly combine SNF and health-related beds because of the flexibility between the two levels of care, with patients often changing from one level of care to another; and (3) the application was denied for lack of public need, not Medicaid non-participation. The Court observed that while there might be a rational basis for approving the application, establishing that fact fell short of establishing that the state's denial of the application was irrational or without substantial evidentiary support.

D) Rates of utilization of existing facilities as evidence of need.

(i) North Miami General Hospital, Inc. v. Office of Community Medical Facilities 355 So.2d 1272 (Fla.Dist.Ct. App. 1978)

A hospital brought an action seeking judicial review of a DPA decision recommending denial under Section 1122 of its project to acquire a CT scanner. The DPA denial was based on absence of need, which it measured by a standard providing that no need was present until existing CT scanners in the area were performing 2,400 scans per year. The 2,400 scan per year utilization rate as a measure of need had not been formally adopted by the DPA as a regulation. The Court reversed the DPA decision and held that insufficient substantial and competent evidence was presented by the DPA before the hearing officer hearing the hospital's application to justify the use of the 2,400/year standard to determine need, because the only testimony supporting the figure was hearsay statements of two physicians and two unauthenticated documents, also hearsay, one of which was a draft report prepared by the Congressional Office of

Technology Assessment and the other of which was a consulting firm study.

(ii) Department of Health and Rehabilitative Services v. Johnson and Johnson Home Health Care, Inc. 447 So.2d 361 (Fla. Dist. Ct. App. 1984)

A home health agency brought an action seeking judicial review of a state agency decision denying its application for a CON to establish a new HHA. The state CON statute required the state agency to review CON applications in context with a set of review criteria including need, quality, financial feasibility, accessibility and the like. State agency rules prescribed a threshold requirement for issuance of a CON for new home health services that each existing provider within the service area achieve an average daily census of 300 patients for the immediately preceding calendar quarter. Two exceptions to this requirements were provided when existing agencies were unable to provide service to all persons in need or when the proposed new agency would foster cost containment for all providers.

The Court struck down the state agency decision, holding that the rule was arbitrary and capricious because: (1) it did not measure quality of service or whether need was being met; and (2) it was predicated on existing providers' explanations that such a level represented optimum administrative efficiency, its stated purpose was to halt HHA proliferation, it was designed to protect the existing industry from competition, and as a consequence there was no reasonable relationship shown between the prohibition of the rule and public health, morals, safety, or welfare. The Court appeared to conclude that the rule was arbitrary and capricious in part because it would bar approvals of new facilities if existing facilities were able but unwilling to reach the 300 patient average daily census level because they were unwilling to provide services of a particular type or for a particular class of patients. The Court observed that the exception to the rule where existing agencies are unable to provide service would not save the rule as long as the exception might not apply if existing providers were able but unwilling to provide service. The Court stated that the cost containment exception was unsupported by data at the time of its adoption and uncertain in its meaning as to what providers were included.

(iii) Suburban Cook County - Du Page County Health Systems Agency, Inc. v. Illinois Health Facilities Planning Board No. 83-L-51705 (Ill. Cir. Ct., Cook Cty. Nov. 15, 1984)

An HSA brought an action seeking judicial review of a state agency decision granting a CON to Alexian, an area hospital, to add an adult cardiac catheterization service. A state

CON regulatory criterion prohibited new adult cardiac catheterization services until each existing service was performing in excess of 500 catheterizations per year. Nine area hospitals had cardiac catheterization services performing less than 500 procedures per year. Claiming that health considerations overrode the financial concerns behind the criterion, the state agency granted the CON on the grounds that Alexian's service would treat overflow catheterization patients from Loyola, an area hospital with an overcrowded cardiac catheterization service and a pre-existing affiliation agreement with Alexian. The state contended that Loyola's use of the existing underutilized catheterization services for overflow patients would not be in the public interest because their staff were not properly trained. The Court reversed the state agency decision, holding that the state agency's cardiac catheterization criterion was on its face mandatory and the state's health concerns could be satisfied without violating the criterion if Loyola established an affiliation agreement with one of the existing services and trained its staff.

(iv) Humana Medical Corp. v. State Health Planning and Development Agency 460 So.2d 1295 (Ala.Civ. App. 1984)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to add beds. The application was denied for failure to satisfy the review criteria of "community need" and "cost containment/less costly alternative" on the grounds that there was an area bed supply excess and that better utilization of existing area hospital beds would foster cost containment. The Court upheld the state agency decision, holding among other things that evidence in the record indicating an excess of hospital beds in the community supported the agency's decision that the application failed to satisfy the community need and cost containment criteria.

(v) Beatrice Manor, Inc. v. Department of Health 362 N.W.2d 45 (Neb. 1985), infra p. 223.

(E) Patient travel time to existing facilities as evidence of need

(i) Mid-Ohio Health Planning Federation v. Certificate of Need Review Board No. 81AP-958 (Ohio.Ct.App. Franklin County, April 1, 1982)

An HSA brought an action seeking judicial review of a SHPDA decision, affirmed on administrative appeal by the state CON Review Board, that a CON be awarded for a hospital replacement/relocation project.

The Court upheld the SHPDA decision, making a number of rulings on procedural and substantive issues. The Court rejected an argument that certain several facts and issues considered by the SHPDA were irrelevant or improper to take into account. One of the challenged factual matters was that patient travel time to existing facilities in the area where the hospital proposed to relocate exceeded 15 minutes. The Court held that it was not improper to consider whether existing facilities near the proposed site offered travel times of 15 minutes even though the state and national standard for accessibility to a hospital is 30 minutes because there is nothing in the law that prohibits an area from trying to achieve, if economically feasible, accessible hospital treatment beyond the minimum level of compliance.

(F) Rural/urban adjustment of need criteria

(i) Beatrice Manor, Inc. v. Department of Health 362 N.W.2d 45 (Neb. 1985)

A long-term care facility brought an action seeking judicial review of a state agency decision denying its application for a CON to add 23 beds to its facility. The application was denied on the basis of community need, cost, and less costly or more effective alternative criteria. The Court held that there was substantial evidence to support the state agency's decision. First, re community need the state agency's regulatory need formula incorporated a maximum statewide long-term care bed/population ratio, which was already exceeded in the facility's proposed service area. State agency regulations permitted individual exceptions from the community need criterion. The state CON statute contained a provision requiring the SHPDA to use review criteria which distinguished between rural and urban areas "to the extent that variable standards will benefit the development of the most appropriate health care system for the health service area". NEB. REV. STAT. §71-5857 (1979). The trial court had held that the statewide need formula was invalid for failure to make this distinction. The Supreme Court reversed, affirming the state agency decision and ruling that the agency regulations complied with the statute by allowing for individual exceptions to the review requirement of consistency with the need formula where convincing evidence was shown that the formula did not accurately reflect community need because the elderly population in the community varied significantly from other areas. The Court indicated that no such convincing showing had been made in this case, observing that the applicant's evidence that it and other nursing homes in the area were operating close to capacity and had waiting lists did not entitle it to a CON because: (1) The evidence confused "need" and "demand" for nursing beds. "Need" focuses on long-range plans to provide required services to an entire population. It is a quantitative analysis. "Demand" connotes an immediate preference on the part of an individual to live in a particular nursing facility. (2)

The facility's evidence only demonstrated a demand without a need. There was no showing that the people on the waiting lists required nursing home care or could not be served by alternate forms of care such as home nursing, day care, or "Meals on Wheels". The state agency had a long-range effort underway to implement these alternatives in order to minimize the need for nursing homes.

(3) Need for unique facilities serving unique populations

(A) Cf. Cheshire Convalescent Center, Inc. v. Commission on Hospitals and Health Care 386 A.2d 264 (Conn.C.P. 1977)

A nursing home brought an action seeking judicial review of a state agency decision denying its application for a CON to construct a 120-bed addition to its facility. The nursing home raised and the Court discussed but did not rule on the argument that the state nursing home bed need formula should not apply to it because it was a unique facility offering a unique set of services of unusually high quality to a population that included patients outside the health service area.

(B) Cf. American International Health Services, Inc. v. Rhode Island Department of Health Nos. 77-3474 and 77-282 (R.I.Super.Ct. Providence County Sept. 11, 1978), cert. den., 396 A.2d 945 (R.I. 1979), app. dism'd., No. 78-355 -Appeal (R.I._____ 1979)

A corporation brought an action seeking judicial review of a state agency decision denying its application for a CON to construct a specialty hospital for detoxification and rehabilitation of patients suffering from the disease of alcoholism. The state agency denied the application on the basis of the statutory CON criteria which required a showing of "public need" for the "construction" and its determination that there was an excess of hospital beds in the state. The applicant argued that the state agency should have considered the public need for alcoholism services and the question whether there were sufficient beds dedicated to alcoholism detoxification and rehabilitation. The Court upheld the state agency, ruling that approval for construction has nothing to do with the services to be rendered at the place where the facilities are located.

(C) Tulsa Area Hospital Council, Inc. v. Oral Roberts University 626 P.2d 316 (Okla. 1981)

An organization of local hospitals brought an action appealing the decision of the SHPDA granting a CON to Oral Roberts University (ORU) to construct a new hospital in Tulsa. The Oklahoma SHPDA had concluded that the project was needed because it would provide a national constituency with a unique form of medical care nowhere else available called holistic medicine, i.e., scientific medicine, laying on of hands, and prayer provided together in a controlled atmosphere. The trial court rejected this finding deciding that the record did not support the conclusion that holistic medicine could not be provided in conventional hospitals in Tulsa and consequently concluding that the SHPDA should have measured the demand for holistic medicine against the existing bed supply in the Tulsa area to ascertain whether need for the project was shown. The Supreme Court reinstated the SHPDA decision, noting that the Oklahoma CON statute's provision for protecting patient choice (and NHPRDA's requirement that special consideration be given entities serving persons outside their areas [Section 1532(c)(7)]) authorized the SHPDA to determine the need for a holistic medicine hospital with a national constituency independent of the need for conventional hospitals.

(D) Pee Dee Regional Health Systems Agency, Inc. v. Department of Health and Environmental Control No. 79-CP-40-3626 (S.C.Ct.C.P. May 13, 1981)

An HSA and others brought an action seeking judicial review of a state agency decision approving an application for a CON to construct a "long-term care rehabilitation facility" described as a unique facility providing both traditional nursing home services and extensive, specialized rehabilitative services. The State Medical Facilities Plan (SMFP) showed no need for additional long-term care beds in the area but did not address the need for the special type of rehabilitative services the project proposed. The state agency used the SMFP as a policy document to guide it in making CON decisions. The Court held that the state was not strictly bound to follow the SMFP in its CON decisions, and that the state had the authority to grant an exception from the SMFP for a unique facility not covered by the Plan. In granting the CON for the "long-term care rehabilitation facility" the Board of Health and Environmental Control indicated that it would assure that the proposed facility would in fact provide unique, needed specialized rehabilitative services and not merely traditional nursing home services (for which no need was indicated in the SMFP) by conditioning the facility's license on the performance of such specialized services. In the course of upholding the Board's decision, the Court concluded that the Board possessed the authority even in the absence of express statutory authorization to attach such a condition to a licensure approval.

(E) Anderson v. Blum 436 N.Y.S.2d 378 (App.Div. 1981)

An adult home brought an action seeking judicial review of the decision of the Commissioner of the State Department of Social Services denying its application for approval of a project to expand its facility. The Court upheld the Commissioner, holding that the Commissioner did not err in declining to consider the special services provided by the adult home to mentally retarded persons because the Commissioner's refusal to do so was based on her conclusion that in view of the state's policy of "deinstitutionalization" placements from institutions for the retarded into private proprietary homes for adults would not be made.

(F) Georgia-Tennessee Regional Health Commission v. Tennessee Health Facilities Commission and Diagnostic Center Hospital No. 80-116-II (Tenn.Ct.App. Jan. 6, 1981)

An HSA brought an action seeking judicial review of a state agency decision granting a CON to expand a hospital. The project was described as providing unique, specialized diagnosis and treatment of coronary and respiratory disorders not available elsewhere. The HSA alleged that: (1) the state agency approval was inconsistent with its HSP which indicated a bed surplus in the area, and (2) the approval was inconsistent with the state CON statute which required review of projects for areawide need and did not authorize special consideration of hospitals providing unique, specialized services. The Court upheld the decision of the state, ruling that the evidence amply justified the decision that the applicant offered specialized care not duplicated elsewhere and that the applicant was therefore not precluded from enlarging by the evidence of a bed surplus in the area indicated by the bed to population ratio.

(G) Cf. In re Certificate of Need Application by Bethany Medical Center 630 P.2d 1136 (Kan. 1981)

The State Department of Health and Environment brought an action appealing the decision of the Kansas Corporation Commission (the administrative agency which heard administrative appeals from Health Department CON decisions) reversing the Department's decision denying Bethany Hospital's application for a CON to acquire a linear accelerator. The Department's criterion for determining need for linear accelerators, based on a portion of the National Guidelines for Health Planning (42 CFR §121.209(a)(2)), was that no additional units should be added until all existing units in the area were performing 6,000 treatments per year. A university hospital in the area had recently acquired one extra high voltage accelerator and had another on order. If the high energy accelerators were counted, need could not be shown. The Department counted them. The Corporation Commission did not, basing its decision on another provision of the National Guidelines (42 CFR §121.209(b)) which provided that "dedicated special purpose and extra high energy machines which have limited but important applications may not perform 6,000 treatments per year and should be evaluated individually by HSAs in the development of Health Systems Plans." The Court upheld the Commission's decision, holding that the Commission's decision was supported by substantial evidence in the record including evidence that high energy machines are not capable of treating as many patients as low energy machines, require more adjustment and more skilled operators, and are not appropriate for "run of the mill" patients, and evidence that the university hospital units would not be used for "run of the mill" patients but would be available as back-up units for Bethany hospital patients needing specialized treatment.

(H) Gulf Coast Hospital, Inc. v. Department of Health and Rehabilitative Services 424 So.2d 86 (Fla.Dist.Ct.App. 1982)

A corporation proposing to construct a new osteopathic 116-bed hospital brought an action seeking judicial review of the state agency's denial of its application. The state CON statute provided that:

> When an application is made for a certificate of need to construct or to expand an osteopathic facility, the need for such facility shall be determined on the basis of the need for and availability of osteopathic services and facilities in the community. (Fla.Stat.Ann. §381.494(2) (1972)).

The state agency interpreted the statute to mean that the need for osteopathic facilities would not be considered apart from the need for allopathic facilities, unless the applicant proved that discrimination against osteopathic physicians made existing allopathic hospitals inaccessible to them. Concluding that existing allopathic facilities in the area were accessible because two of the four of them expressed a willingness to consider applications of osteopathic physicians for staff privileges and state law forbade discrimination against osteopathic physicians in the granting of staff membership and clinical privileges, the state denied the application on the basis of the excess bed supply in existing allopathic facilities. The Court reversed, holding that the need for osteopathic facilities should be determined separately from the need for allopathic facilities because, by enactment of the language set forth above the legislature intended to recognize the interests of both osteopathic physicians and their patients in obtaining care in a facility devoted primarily to the practice of osteopathic medicine and potential or actual access to allopathic facilities, discrimination against osteopaths, or the lack thereof are not factors referred to expressly or by implication in the statute. However, the Court concluded that plaintiffs had failed to adduce sufficient statistical evidence to establish the need for 116 osteopathic beds, and remanded to the agency to take additional evidence and authorize such sized facility as might be needed. A specially concurring opinion argued that the state agency's interpretation of the statute set forth above was within its discretion, but that the agency interpretation had been overruled by another statute, adopted during the pendency of this court action, which prohibited discrimination in the granting of staff membership/clinical privileges and provided that nothing therein should be construed by the state to require a CON applicant to establish proof of discrimination as a precondition to obtaining a CON.

(I) Northwest Health Care, Inc. v. Idaho Health Facilities Review Board No. 76772 (Idaho Dist.Ct. Ada Cty. Jan. 27, 1983)

A nursing home brought an action seeking judicial review of a state agency decision granting a CON to its competitor, a retirement residence center, to construct a 20 bed nursing home unit in the center. The nursing home alleged that there was no need for the project because of an area nursing home bed surplus. It also asserted that the state violated the purposes of the state CON statute by treating the proposed unit as a unique facility and determining the need for it based on considerations other than absolute necessity, including considering the fact that the nursing home unit would be associated with the retirement center.

The Court upheld the state agency decision, holding among other things that there was substantial evidence to support the state agency's decision on need because: (1) the proposed unit would have a minimal impact on the current surplus of nursing home facilities since many residents of the center would come from outside the service area and the nursing beds would be available only to center residents; and (2) the center was qualitatively different from the traditional nursing home and the need for it could be measured apart from the need for conventional nursing home beds.

(J) Cf. In re Rev. of Dec. of Kansas Corp. Com'n 659 P.2d 199 (Kan. 1983)

A competitor (Bethany Medical Center) brought an action appealing the decision of KCC (the state agency which heard administrative appeals of CON decisions) to grant a CON to Providence-St. Margaret Health Center to acquire a 6MeV linear accelerator. KCC had reversed the SHPDA denial of the application.

At the time of the Providence application there were four linear accelerators in the service area: two low energy units and two extra high energy units, all located at a university hospital. In addition, after the SHPDA decision but prior to the KCC decision the State Supreme Court had affirmed an earlier KCC decision granting Bethany a CON for a low-energy linear accelerator. (*In re Certificate of Need Applicaiton by Bethany Medical Center*, *supra*.) The state used the linear accelerator need methodology set forth in the National Guidelines for Health Planning (42 C.F.R. §121.209) which among other things provided that: (1) each unit should serve a population of 150K and treat 300 cancer cases annually; (2) no additional units should be approved until all existing general purpose units in the area were performing 6,000 treatments per year; and (3) dedicated special purpose and extra high-energy machines which have limited but important applications may not perform 6,000 treatments per year and should be evaluated individually by HSAs in the (42 C.F.R. §121.209(b)).

The SHPDA had "individually evaluated" the extra high-energy machines by treating the two as if they were one machine for purposes of the need formulae (giving the area three or four existing units, depending upon whether Bethany's unit was counted) and apparently had denied on the grounds that the population/unit and cancer cases/unit formulae projected a need for fewer than four units. KCC "individually evaluated" the two machines by excluding them altogether from consideration in applying the need formulae.

Apparently concluding that KCC's jurisdiction was limited to considering whether there was substantial evidence in the record to support the SHPDA's decision, the Court held that KCC erred in overturning the SHPDA decision because in doing so KCC ignored the SHPDA's "individual evaluation" of the two extra high energy units. [Compare the Court's earlier ruling in *In re Certificate of Need Application by Bethany Medical Center*, which criticized the SHPDA for counting each extra high energy unit individually for purposes of the need formulae as a failure to individually evaluate the units, and upheld a KCC decision which excluded the two units from consideration altogether.]

(K) *Cf. Florida Medical Center v. Dept. of Health and Rehabilitative Services* 463 So. 2d 381 (Fla. Dist. Ct. App. 1985)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to acquire a MRI unit. The state agency denied the application, in part on the grounds that placement of MRI should be limited to research facilities. The Court reversed the state agency and ordered a CON issued to the hospital. The Court questioned in dicta whether the statutory CON review criteria could be construed to encompass a research facility limitation on MRI placement, doubting whether such a limitation could be based on the state's statutory criterion of "need for research and educational facilities."

(4) Definition of community or regional need.

(A) New Britain General Hospital v. Commission on Hospitals and Health Care No. 233 575 (Conn.Super.Ct. Hartford Jud.Dist. Dec. 26, 1979)

A hospital brought an action seeking judicial review of a decision of the state agency denying its application for a CON to acquire a CT scanner. The state CON statute provided that the state agency should consider "the duplication of service by institutions and facilities in the area served" and "the community or regional need for any particular function." The state agency acquiesced in the applicant's definition of "area served" as the geographic area reflecting the hospital's historic referral area. The Court reversed, holding that the statutory provision requiring consideration of "community or regional need" required the state agency to undertake a consideration of need which went beyond the parameters of the applicant's service area because otherwise the statutory language on community need would be superfluous.

(B) North Charleston Medical Center, Inc. v. South Carolina Department of Health and Environmental Control No.___ (S.C. County Court Charleston County November 21, 1975), reprinted in HOSPITAL FRANCHISING LAW AND REGULATION (A SOUTH CAROLINA CASEBOOK) 369 (1979)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to construct a new facility. The state statute provided for issuance of CONs to projects that "will meet public needs of the community where the facility is to be located." The new hospital was to be located in a suburban city which had no existing hospital within its boundaries. The applicant alleged that the state agency's refusal to restrict its consideration to the confined geographic area of the city and its insistence on considering the larger metropolitan area was beyond its statutory authority. The Court upheld the state agency decision, holding among other things that the agency had the authority to consider the larger areawide need for services because: (1) the state legitimately concluded that the only means of assuring that community needs can be met is planning on an areawide basis, and (2) the United States Department of Commerce designation of a larger area as a Standard Metropolitan Statistical Area (SMSA) is strong support for the proposition that the city does not stand alone as a separate community.

(C) In re Certificate of Need Application by Community Psychiatric Centers, Inc. 676 P.2d 107 (Kansas 1984)

Two psychiatric hospital applicants, Excepticon and CPC, brought separate actions seeking judicial review of State Agency (KDHE) denials of their applications to construct new facilities in Johnson County.

The Court upheld KDHE's denials as supported by substantial evidence. KDHE denied both applications for failure to satisfy its review criteria of community need and cost containment. It evaluated the applications on the basis of community need and cost containment impact in a seven-county health service area which included Johnson County and concluded that the new facilities, though more cost-effective than existing facilities, would increase the cost of health care in the existing facilities in the area in which bed space and care was available to the general public. The Court rejected the argument raised by the applicants that the CONs should be approved because there was a need for additional facilities to provide bed space and psychiatric treatment in Johnson County, observing that if this were the test to be applied, then each county included in the seven-county area could show a need for expansion of health care facilities when considered separately from the surrounding area, thereby defeating the legislative requirement of a statewide health program.

(5) Miscellaneous need criterion cases

(A) Iowa Health Systems Agency, Inc. v. Wade 327 N.E.2d 732 (Iowa 1982)

An HSA and a DPA brought an action seeking judicial review in state court of a hearing officer's decision making findings recommending approval of reimbursement under Section 1122 for a project to replace an existing facility. The hearing officer had reversed the negative recommendation of the DPA, which was based on the hospital's failure to satisfy the need, economic feasibility, and cost effectiveness criteria, for lack of substantial evidence. The Court reversed, holding that although there was evidence from which the DPA could have drawn a contrary conclusion, its decision was supported by substantial evidence because with regard to the need criterion the proposed services were already being furnished by other area hospitals, the hospital's occupancy rate was the lowest in the city and dropping, similar services were not utilized to capacity, area residents, when surveyed, expressed satisfaction with existing facilities, and the projected population increases in the area were the result of suburban relocation by existing area residents, who would continue to use their previous doctors and hospitals.

(B) Beatrice Manor, Inc. v. Dept. of Health 362 N.W.2d 45 (Neb. 1985)

A long-term care facility brought an action seeking judicial review of a state agency decision denying its application for a CON to add 23 beds to its facility. The application was denied on the basis of community need as measured by the state agency's regulatory need formula and other factors. The Court affirmed the agency decision, holding among other things that there was substantial evidence to support the agency's finding of absence of need because, in addition to absence of need under the formula, there was evidence that within its proposed six-county service area the proposed facility would primarily serve a particular county which was more overbedded than the service area as a whole and whose elderly population was decreasing.

b. The Less Costly Alternative/Cost-Effectiveness Criterion

(1) West Virginia Health Systems Agency, Inc. v. State Health Planning and Development Agency No. AP-CA-80-1 (W.Va.Cir.Ct. Kanawha County July 2, 1980)

An HSA brought an action seeking judicial review of a state agency decision granting a CON for construction of a replacement hospital. The SHPDA interpreted a statutory criterion requiring it to determine that "the development of superior alternatives in the terms of cost, efficiency, and appropriateness is not practicable" to only require consideration of specific alternative proposals, not to require consideration of potential or possible alternative proposals. The Court upheld the SHPDA's interpretation.

(2) Iowa Health Systems Agency, Inc. v. Wade 327 N.E.2d 732 (Iowa 1982)

An HSA and a DPA brought an action seeking judicial review in state court of a hearing officer's decision making findings recommending approval of reimbursement under Section 1122 for a project to replace an existing facility. The hearing officer had reversed the negative recommendation of the DPA, which was based on the hospital's failure to satisfy the need, economic feasibility, and cost effectiveness criteria, for lack of substantial evidence. The Court reversed, holding that although there was evidence from which the DPA could have drawn a contrary conclusion, its decision was supported by substantial evidence because with regard to the cost effectiveness/improved quality criterion less expensive alternatives had not been adequately presented, the present facility was Medicare-approved and accredited, and while institutional benefits would accrue the project was a luxury purchased at the consumer's expense because it did not fill an unmet need.

(3) County of Dodge v. Dept. of Health 355 N.W.2d 775 (Neb. 1984)

A hospital brought an action seeking judicial review of a state agency decision approving its application to acquire nuclear medicine equipment on the condition that it acquire the equipment by outright purchase using reserve funds, rather than leasing the equipment as the hospital proposed. The state CON statute authorized the purchase, acquisition, or lease of clinical equipment upon a finding of compliance with review criteria including immediate and long-term financial feasibility, probable impact on the applicant's costs and charges, and less costly alternative/cost effectiveness. The state agency concluded that leasing would be more advantageous to the hospital than purchase because the hospital would receive more Medicare/Medicaid reimbursement, but less advantageous to health care consumers and taxpayers who would bear the cost of increased reimbursement. The Court held that the state agency's decision was based on an improper criterion because nowhere in the state CON statute was there any explicit reference or language susceptible to reasonable inference that taxpayers' cost was a valid CON consideration. Likewise, the derivative cost to taxpayers on account of the governmental programs of Medicare and Medicaid was not a criterion, and whether it should be or not was a matter with far-reaching fiscal ramifications more appropriately dealt with by the legislature. A criterion taking such costs into account would effectively prohibit all CON applications to lease equipment, frustrating the legislative intent to authorize at least some such transactions.

(4) In re Certificate of Need Application by Community Psychiatric, Inc. 676 P.2d 107 (Kansas 1984)

Two psychiatric hospital applicants, Excepticon and CPC, brought separate actions seeking judicial review of State Agency (KDHE) denials of their applications to construct new facilities in Johnson County. The Court upheld KDHE's denials as supported by substantial evidence. KDHE denied both applications for failure to satisfy its review criteria of community need and cost containment. It evaluated the applications on the basis of community need and cost containment impact in a seven-county health service area which included Johnson County and concluded that the new facilities, though more cost-effective than existing facilities, would increase the cost of health care in the existing facilities in the area in which bed space and care was available to the general public. The Court rejected the argument raised by the applicants that the CONs should be approved because there was a need for additional facilities to provide bed space and psychiatric treatment in Johnson County, observing that if this were the test to be applied, then each county included in the seven-county area could show a need for expansion of health care facilities when considered separately from the surrounding area, thereby defeating the legislative requirement of a statewide health program.

(5) Humana Medical Corp. v. State Health Planning and Development Agency 460 So.2d 1295 (Ala.Civ.App. 1984)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to add beds. The application was denied for failure to satisfy the review criteria of "community need" and "cost containment/less costly alternative" on the grounds that there was an area bed supply excess and that better utilization of existing area hospital beds would foster cost containment. The Court held that: (1) the standard of judicial review of state CON decisions was the "arbitrary, capricious, or not made in compliance with applicable law" provision of the NHPRDA regulations (42 C.F.R. §123.410 (14)(i)) which was incorporated by reference into the state CON statute; and (2) evidence in the record indicating an excess of hospital beds in the community supported the agency's decision that the application failed to satisfy the community need and cost containment criteria.

(6) Therapeutic Community Residence v. Minnesota Dept. of Health 351 N.W.2d 647 (Minn. Ct. App. 1984)

A community residential facility (TCR) brought an action seeking judicial review of a state agency denial of its application for a certificate of need to establish an ICF/MR facility. TCR alleged that its facility would be unique in that it would specialize in treating mentally-ill retarded persons. The state agency denied the application on the grounds that: (1) TCR's proposed rates were significantly higher than the average rates for similar facilities; (2) there was no evidence in the record that TCR would succeed in eventually moving patients to less expensive facilities; and (3) there was no evidence that existing state hospitals did not have the capability to meet the needs of the proposed patient population.

On appeal, the Court reversed the state agency denial and ordered a CON issued. The Court held that proposed rates might properly be considered in reviewing CON applications because providing care at the lowest possible cost is an express purpose of the state CON statute. However, it ruled that the state agency failed to consider the facts that the State Welfare Department had approved TCR's proposed rate and that TCR's rate, though higher than the overall average, was not significantly different from the rate for comparable facilities serving mentally-ill retarded persons. The Court also found that since TCR's rates were not significantly higher than comparable facilities the absence of evidence that patients would be transferred was not important. Finally, the Court noted that placement of mentally-retarded persons in state hospitals was not an acceptable alternative because state hospitals were an inappropriate setting for such persons and the per diem patient costs in state hospitals were higher than TCR's proposed rates.

(7) Mercy Health Center v. State Health Facilities Council 360 N.W.2d 808 (Iowa 1985)

A hospital brought an action seeking judicial review of a state health facilities council (SHFC) decision denying its application for a CON to convert its acute care facility into an "elder care center." The project involved, among other things, establishment of a new SNF unit and renovation of space to residential apartment, mini-shopping mall, and other non-medical uses. The SHFC denied the application on the grounds of oversupply of SNF beds in the community and because its financing arrangement would result in cross-subsidization (i.e., revenues from health care services would contribute to non-health care services which could be provided by non-health care industries).

The Court then held that the SHFC's consideration of cross-subsidization was not a misapplication of the statutory criteria or an application of an unpromulgated rule because: (1) The statutory CON criteria are not exclusive in the sense of prohibiting the SHFC from considering matters not specifically enumerated in the statutory list of criteria, although the SHFC must consider the statutory criteria; (2) the SHFC's consideration of cross-subsidization was not the application of an unpromulgated rule, but rather an authorized application of the statutory criteria requiring consideration of immediate and long-term financial feasibility, probable impact on health service costs and charges, and availability of less costly, more efficient alternatives since cross-subsidization is a factual matter which bears directly on these considerations. Finally, the Court held that the SHFC's decision was supported by substantial evidence, observing that the case turned on the cardinal rule of administrative law that judgment calls are the province of the administrative tribunal and not of the courts.

(8) Beatrice Manor, Inc. v. Department of Health 362 N.W.2d 45 (Neb. 1985)

A long-term care facility brought an action seeking judicial review of a state agency decision denying its application for a CON to add 23 beds to its facility. The application was denied on the basis of community need, cost, and less costly or more effective alternative criteria. The Court upheld the state agency decision. It held that the applicant's evidence that it and other nursing homes in the area were operating close to capacity and had waiting lists did not entitle the applicant to a CON because, among other things, there was no showing that the people on the waiting lists required nursing home care or could not be served by alternate forms of care such as home nursing, day care, or "Meals on Wheels". The state agency had a long-range effort underway to implement these alternatives in order to minimize the need for nursing homes. The Court also held that there was insufficient evidence that the proposed facility was the best alternative to serve any existing demand because there was no evidence that persons on the facility's waiting list required nursing beds rather than in-home care. Finally, the Court held that cost factors weighed against the project because: (1) since no need for the project was established, the capital cost of the project was not reasonable; and (2) it was unlikely that if the project were implemented the facility could maintain occupancy at the level necessary to avoid reimbursement penalties tied to low occupancy.

(9) Collier Medical Center, Inc. v. Dept. of Health and Rehabilitative Services 462 So.2d 83 (Fla.Dist.Ct.App. 1985)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a certificate of need to construct a new hospital which would serve two counties. Three existing competitor hospitals in the two counties, one of which also operated a "primary care center emergency room" in the area and the other two of which had large charity case loads, had been permitted to intervene in the hospital's administrative hearing as persons whose "substantial interests" were affected by the proposed agency action. The state agency denied the application in part on grounds of unnecessary duplication, financial infeasibility, and substantial revenue loss to the two competitor hospitals. The Court upheld the agency decision. Re unnecessary duplication it ruled that there was expert testimony that primary care centers such as that already operated by the competitor would provide a less costly alternative to the proposed hospital's emergency room, and testimony that as a consequence the proposed hospital would needlessly duplicate existing services. Re financial feasibility the evidence supported the state's finding that the proposed facility would not be financially feasible because of: (a) duplication of services; and (b) increased costs to the two competitor hospitals with high charity loads attributable to the proposed facility siphoning off their paying patients without an accompanying shouldering of the area's indigent care burden. Re impact on the competitors' revenues there was substantial evidence in the form of testimony from the chief financial officers of the two competitors that each would suffer significant revenue reductions as a result of loss to the proposed facility of a percentage of their paying patients, with an accompanying retention of non-paying patients.

c. Availability of Health Personnel Criterion

(1) Humana of Tennessee v. Tennessee Health Facilities Commission 551 S.W. 2d 664 (Tenn. 1977)

A competitor brought an action seeking judicial review of a decision of the state agency granting a CON to construct a specialty care hospital. The plaintiff alleged that the state had approved the application simply because several specialist physicians had indicated that they would locate their practices in the area, which was medically underserved, only if the proposed hospital were approved. The Court upheld the state agency decision, holding that the record indicated that the state agency decision was not based solely on this evidence and observed that the agency could legitimately consider such evidence because one of the statutory CON criteria was the availability of sufficient manpower in the several professional disciplines required.

d. Project Cost and Financial Feasibility Criteria

(1) Schultz v. Public Health Council 364 N.Y.S. 2d 566 (App.Div. 1975)

A physician brought an action seeking judicial review of a state agency decision denying his application for a CON to construct a nursing home to be operated in conjunction with an existing hospital owned by the physician. The nursing home would utilize the hospital laboratory facilities and other hospital facilities such as laundry, and would be physically connected to the hospital. The Court reversed the state agency decision, holding among other things that it was proper for the state agency to consider the financial stability of the hospital in the course of considering the financial aspects of the nursing home project because of the interrelatedness of the proposed nursing home and the hospital.

(2) National Nephrology Foundation v. Dougherty 351 A.2d 392 (N.J.Super.App.Div. 1976)

A hospital brought actions appealing the denial of its application for a CON to construct an intermediate renal dialysis facility and the contemporaneous approval of a competitor's application. The hospital alleged that the state agency ignored the statutory criterion relating to cost of the proposed facility since its application was disapproved even though it presented evidence that it could do the job more cheaply than the other applicant. The Court upheld the state agency decision, noting that the state was not obliged to accept the hospital's cost projections as absolutely reliable, cost was but one of the several factors which the statute required the agency to consider, and the fact that the agency did not give the cost factor the weight, in relation to the other criteria, that the hospital would have preferred did not mean that it failed to consider cost.

(3) Farkas v. Moore 367 N.Y.S.2d 1 (App.Div. 1979)

Applicants for establishment and construction of a new health facility brought an action seeking judicial review of a state agency decision denying their application on the basis of failure to meet the statutory criterion that the financial resources and sources of future revenue of the facility be satisfactory. The Court upheld the state agency decision, holding that there was substantial evidence to indicate inadequate financing where substantially all of the applicants' net worth would have to be applied to finance the project and a third of that net worth consisted of an ambiguous letter of credit and an unresolved claim for money pending against the state.

(4) Mid-Ohio Health Planning Federation v. Certificate of Need Review Board No. 81AP-958 (Ohio.Ct.App. Franklin County, April 1, 1982)

An HSA brought an action seeking judicial review of a SHPDA decision, affirmed on administrative appeal by the state CON Review Board, that a CON be awarded for a hospital replacement/relocation project.

The Court upheld the SHPDA decision, making a number of rulings on procedural and substantive issues. The Court rejected the argument that several facts and issues considered by the SHPDA were irrelevant or improper to take into account. Two of the challenged factual matters were that the hospital was in present financial difficulty and needed to relocate to survive financially, and a comparison of the costs of relocation vs. replacement at the existing site. The Court concluded that the financial status of the hospital and relocations vs. replacement costs were relevant to the review criterion requiring consideration of the relationship of the services proposed to be provided to the existing health care system of the area in which such services are proposed to be provided.

(5) Iowa Health Systems Agency, Inc. v. Wade 327 N.E.2d 732 (Iowa 1982)

An HSA and a DPA brought an action seeking judicial review in state court of a hearing officer's decision making findings recommending approval of reimbursement under Section 1122 for a project to replace an existing facility. The hearing officer had reversed the negative recommendation of the DPA, which was based on the hospital's failure to satisfy the need, economic feasibility, and cost effectiveness criteria, for lack of substantial evidence. The Court reversed, holding that although there was evidence from which the DPA could have drawn a contrary conclusion, its decision was supported by substantial evidence because: with regard to the economic feasibility criterion the hospital had a low and declining occupancy rate, the projected cost-charge ratio indicated a large burden would be imposed on private pay patients, and the hospital was not funding depreciation but using depreciation to pay its indebtedness.

(6) County of Dodge v. Dept. of Health 355 N.W.2d 775 (Neb. 1984)

A hospital brought an action seeking judicial review of a state agency decision approving its application to acquire nuclear medicine equipment on the condition that it acquire the equipment by outright purchase using reserve funds, rather than leasing the equipment as the hospital proposed. The state CON statute authorized the purchase, acquisition, or lease of clinical equipment upon a finding of compliance with review criteria including immediate and long-term financial feasibility, probable impact on the applicant's costs and charges, and less costly alternative/cost effectiveness. The state agency concluded that leasing would be more advantageous to the hospital than purchase because the hospital would receive more Medicare/Medicaid reimbursement, but less advantageous to health care consumers and taxpayers who would bear the cost of increased reimbursement. The Court held that the state agency's decision was based on an improper criterion because nowhere in the state CON statute was there any explicit reference or language susceptible to reasonable inference that taxpayers' cost was a valid CON consideration. Likewise, the derivative cost to taxpayers on account of the governmental programs of Medicare and Medicaid was not a criterion, and whether it should be or not was a matter with far-reaching fiscal ramifications more appropriately dealt with by the legislature. A criterion taking such costs into account would effectively prohibit all CON applications to lease equipment, frustrating the legislative intent to authorize at least some such transactions.

(7) Mercy Health Center v. State Health Facilities Council 360 N.W.2d 808 (Iowa 1985)

A hospital brought an action seeking judicial review of a state health facilities council (SHFC) decision denying its application for a CON to convert its acute care facility into an "elder care center." The project involved, among other things, establishment of a new SNF unit and renovation of space to residential apartment, mini-shopping mall, and other non-medical uses. The SHFC denied the application on the grounds of oversupply of SNF beds in the community and because its financing arrangement would result in cross-subsidization (i.e., revenues from health care services would contribute to non-health care services which could be provided by non-health care industries).

The Court then held that the SHFC's consideration of cross-subsidization was not a misapplication of the statutory criteria or an application of an unpromulgated rule because: (1) The statutory CON criteria are not exclusive in the sense of prohibiting the SHFC from considering matters not specifically enumerated in the statutory list of criteria, although the SHFC must consider the statutory criteria; (2) the SHFC's consideration of cross-subsidization was not the application of an unpromulgated rule, but rather an authorized application of the statutory criteria requiring consideration of immediate and long-term financial feasibility, probable impact on health service costs and charges, and availability of less costly, more efficient alternatives since cross-subsidization is a factual matter which bears directly on these considerations. Finally, the Court held that the SHFC's decision was supported by substantial evidence, observing that the case turned on the cardinal rule of administrative law that judgment calls are the province of the administrative tribunal and not of the courts.

(8) Shawnee Mission Medical Center v. Kansas Department of Health and Environment 685 P.2d 880 (Kan. 1984)

A hospital brought an action seeking judicial review of a KDHE decision denying its application for a CON to relocate and expand its "Alcoholism Recovery Unit" out of the hospital and into a "freestanding" unit. The project was denied in part on the basis of failure to satisfy the "cost containment" review criterion. The hospital argued that the project satisfied the cost containment criterion because: (1) it would increase efficiency by integrating inpatient and outpatient alcoholism programs; and (2) it would result in cost savings because as a freestanding unit it would no longer be allocated a portion of the utility costs of the hospital building. The Court held that there was substantial evidence to support KDHE's denial of the application because: (1) there was evidence that the anticipated utility savings were less than expected and that the operating expenses of the relocated unit would exceed those in the existing unit; (2) the increased operating expenses of the project were to be offset by a substantial increase in patient charges rather than the improved cost-effectiveness of the project; and (3) although the project would utilize at least some desirable and efficiency-enhancing sharing of space, staff, and supplies, KDHE was charged with the duty under the review criterion of cost containment of weighing the desirability and efficiency of the project against its increased costs; and (a) the rapidly growing costs of medical services must be curtailed, especially when the same or like services are available in the service area or can be provided at a lesser cost; and (b) the anticipated 42% increase in alcoholism recovery patient charges resulting from the project was in itself a substantial increase in health care costs.

(9) Therapeutic Community Residence v. Minnesota Dept. of Health 351 N.W.2d 647 (Minn. Ct. App. 1984)

A community residential facility (TCR) brought an action seeking judicial review of a state agency denial of its application for a certificate of need to establish an ICF/MR facility. TCR alleged that its facility would be unique in that it would specialize in treating mentally-ill retarded persons. The state agency denied the application on the grounds that: (1) TCR's proposed rates were significantly higher than the average rates for similar facilities; (2) there was no evidence in the record that TCR would succeed in eventually moving patients to less expensive facilities; and (3) there was no evidence that existing state hospitals did not have the capability to meet the needs of the proposed patient population.

On appeal, the Court reversed the state agency denial and ordered a CON issued. The Court held that proposed rates might properly be considered in reviewing CON applications because providing care at the lowest possible cost is an express purpose of the state CON statute. However, it ruled that the state agency failed to consider the facts that the State Welfare Department had approved TCR's proposed rate and that TCR's rate, though higher than the overall average, was not significantly different from the rate for comparable facilities serving mentally-ill retarded persons. The Court also found that since TCR's rates were not significantly higher than comparable facilities the absence of evidence that patients would be transferred was not important. Finally, the Court noted that placement of mentally-retarded persons in state hospitals was not an acceptable alternative because state hospitals were an inappropriate setting for such persons and the per diem patient costs in state hospitals were higher than TCR's proposed rates.

(10) Collier Medical Center, Inc. v. Dept. of Health and Rehabilitative Services 462 So.2d 83 (Fla. Dist. Ct. App. 1985)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a certificate of need to construct a new hospital which would serve two counties. Three existing competitor hospitals in the two counties, one of which also operated a "primary care center emergency room" in the area and the other two of which had large charity case loads, had been permitted to intervene in the hospital's administrative hearing as persons whose "substantial interests" were affected by the proposed agency action. The state agency denied the application in part on grounds of financial infeasibility and substantial revenue loss to the two competitor hospitals. The Court upheld the agency decision. The Court held that there was substantial evidence in the record to support the agency's decision to deny because: (1) re unnecessary duplication there was expert testimony that primary care centers such as that already operated by the competitor would provide a less costly alternative to the proposed hospital's emergency room, and testimony that as a consequence the proposed hospital would needlessly duplicate existing services; (2) re financial feasibility the evidence supported the state's finding that the proposed facility would not be financially feasible because of: (a) duplication of services; and (b) increased costs to the two competitor hospitals with high charity loads attributable to the proposed facility siphoning off their paying patients without an accompanying shouldering of the area's indigent care burden; and (3) re impact on the competitors' revenues there was substantial evidence in the form of testimony from the chief financial officers of the two competitors that each would suffer significant revenue reductions as a result of loss to the proposed facility of a percentage of their paying patients, with an accompanying retention of non-paying patients.

(11) Beatrice Manor, Inc. v. Dept. of Health 362 N.W.2d 45 (Neb. 1985)

A long-term care facility brought an action seeking judicial review of a state agency decision denying its application for a CON to add 23 beds to its facility. The application was denied on the basis of community need, cost, and less costly or more effective alternative criteria. The Court held that there was substantial evidence to support the state agency's decision. The Court held that cost factors weighed against the project because: (1) since no need for the project was established, the capital cost of the project was not reasonable; and (2) it was unlikely that if the project were implemented the facility could maintain occupancy at the level necessary to avoid reimbursement penalties tied to low occupancy.

e. Criteria Establishing a Preference for Existing Facilities

(1) Cf. Lakeside Mercy Hospital v. Indiana State Board of Health 421 F.Supp. 193 (N.D.Ind. 1976), aff'd mem., 547 F.2d 1170 (7th Cir. 1976)

A corporation formed to construct a hospital brought an action seeking, among other things, to enjoin the DPA from acting on several competitor hospitals' joint CON applications. In late 1974 plaintiff Lakeside Mercy and Community Hospital of Fort Wayne (another corporation formed to construct a hospital) filed competing applications for approval under Section 1122 to construct a new hospital. Three existing hospitals in the area also filed competing applications to add beds to their facilities, but their applications were filed later and consequently were at an earlier stage in the review process. The review criteria identified a need for 176 additional beds but did not authorize the construction of a new hospital to meet that need. When its application was the first to be denied, Community Hospital of Fort Wayne obtained an injunction against further review of the four applications while it sought judicial review of its denial. During the pendency of that judicial review the three existing hospitals initiated a request and ultimately received permission from the DPA to amend their competing applications by filing a joint proposal allocating the 176 needed beds among themselves. In its order denying relief to Community Hospital, the state trial court granted the request of the three existing hospitals for an order enjoining the DPA from proceeding with Lakeside's application until their joint proposal had caught up with Lakeside's in the review process. Eventually, the DPA recommended approval of the joint proposal and denial of Lakeside's application. Lakeside claimed that the DPA and the existing hospitals conspired to obtain the injunction against proceeding with Lakeside's application until the joint proposal caught up in order to exclude Lakeside and improperly favor the existing hospitals, violating Lakeside's rights to due process and equal protection. The Court held that the DPA's encouragement of the joint proposal was not improper because the DPA was justifiably concerned that it have before it an acceptable proposal and neither Lakeside's application nor the competing applications by the existing hospitals conformed to the criteria. There was no improper favoritism toward the existing hospitals, because as a practical matter conforming proposals could come only from them.

(2) Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission No. 80-200439-AA (Mich.Cir.Ct. Oakland County March 27, 1981), aff'd, 312 N.W. 2d 422 (Mich.App. 1981)

A hospital corporation brought an action seeking judicial review of a state agency denial of its application for a CON to construct a new hospital. The state agency decision was based in part on an unpublished criterion which created a preference for existing facilities including providing that "the highest priority will be granted to existing facilities seeking a CON to modernize or correct licensing deficiencies." The state agency justified this preference as being inherent in the CON statutory policy and a necessary means of encouraging hospitals to bring facilities into compliance with licensure standards. There was evidence that at the time plaintiff's application was being reviewed the state agency knew that the existing hospital in town would soon be applying for a CON to rebuild its facility to remedy licensing deficiencies. The Court held that the state agency preference for existing facilities was beyond statutory authorization because: (1) the state CON statute did not evince a legislative intent to prefer and perpetuate existing facilities, and (2) the CON statute was not a licensing measure nor did it evidence a legislative intent to encourage remedial action by facilities with licensing deficiencies.

(3) *Cf. Collier Medical Center, Inc. v. Dept. of Health and Rehabilitative Services* 462 So.2d 83 (Fla. Dist. Ct. App. 1985), *supra* p. 241

f. Community Support Criterion

(1) *Nehlich v. South Dakota Comprehensive Health Planning Agency* 290 N.W.2d 447 (S.D. 1980)

The proponents of a proposed intermediate care facility brought an action seeking judicial review of the denial by the state agency of their application for a CON to construct the facility. The Court upheld the agency denial holding, among other things, that evidence of strong community interest and overwhelming support for the facility was not determinative as to whether the project would be financially feasible.

g. "Relationship of Project to HSP" Criterion

(1) *West Virginia Health Systems Agency, Inc. v. State Health Planning and Development Agency* Civ. No. AP-CA-80-1 (W.Va.Cir.Ct. Kanawha County July 2, 1980)

An HSA brought an action seeking judicial review of a state agency decision granting a CON for construction of a replacement hospital. The HSA alleged that the state agency erred in approving the application because the proposed project was not in compliance with the HSP's objectives relating to quality of care. The state statutory criteria required the state to "consider" the various criteria in making its determination as to whether a certificate of need should be issued including considering "the relationship of the health services being reviewed to the applicable health systems plan and annual implementation plan adopted by the designated health systems agency...". In upholding the SHPDA decision the Court held that rigid compliance with each objective of the HSP or with each criterion of the CON statute and regulations was not required. Substantial evidence in the record as a whole indicating substantial compliance with the HSP was sufficient grounds for upholding the SHPDA decision because the statutory language looked to the relationship with the plan as a whole, not to compliance with each part of the plan.

h. "Relationship of Project to State Health Plan" Criterion

(1) Cf. Olathe Hospital Foundation v. Extendicare, Inc. 539 P.2d 1 (Kan. 1975)

Several hospitals brought an action seeking judicial review of a state agency appeals panel's final decision granting a CON to their competitor to construct a new hospital. The Court held that the state did not err in failing to consider the State Medical Facilities Plan because the Plan was irrelevant in a CON review since the primary purpose of the State Plan and the purpose of its enabling legislation was to qualify the state for its share of Hill-Burton funds and the hospital did not apply for Hill-Burton funding.

(2) Pee Dee Regional Health Systems Agency, Inc. v. Department of Health and Environmental Control No. 79-CP-40-3626 (S.C.Ct.C.P. May 13, 1981)

An HSA and others brought an action seeking judicial review of a state agency decision approving an application for a CON to construct a "long-term care rehabilitation facility" described as a unique facility providing both traditional nursing home services and extensive, specialized rehabilitative services. The State Medical Facilities Plan (SMFP) showed no need for additional long-term care beds in the area but did not address the need for the special type of rehabilitative services the project proposed. The state agency used the SMFP as a policy document to guide it in making CON decisions. The Court held that the state was not strictly bound to follow the SMFP in its CON decisions, and that the state had the authority to grant an exception from the SMFP for a unique facility not covered by the Plan. In granting the CON for the "long-term care rehabilitation facility" the Board of Health and Environmental Control indicated that it would assure that the proposed facility would in fact provide unique, needed specialized rehabilitative services and not merely traditional nursing home services (for which no need was indicated in the SMFP) by conditioning the facility's license on the performance of such specialized services. The Court concluded that the Board possessed the authority even in the absence of express statutory authorization to attach such a condition to a licensure approval.

(3) Cf. Martin County Nursing Center v. Medco Centers, Inc. 441 N.E.2d 964 (Ind. App. 1982)

A nursing home brought an action seeking to reinstate a DPA hearing officer's decision making findings recommending approval under Section 1122 of its project to construct a new 60 bed nursing home. The nursing home (Martin) had filed an 1122 application competing with that of Medco (the existing facility in the area which proposed a replacement/expansion project). The State Health Plan projected a bed need in the area which the Medco project would satisfy and which the Martin project would exceed. A witness at the fair hearing testified that notwithstanding the Plan projection there was an areawide need for the number of beds which the Martin project proposed. The hearing officer relied upon this testimony, among other things, in ruling in favor of Martin and against Medco. With respect to the need criterion the trial court which heard Mecdo's petition for judicial review relied exclusively on the Plan and ruled against Martin.

The Court of Appeals reversed, holding that: (1) there was substantial evidence to support the hearing officer's decision on need, because the DPA's bed need projection formula was not conclusive proof of need but merely some evidence of need, and the hearing officer was not constrained by the formula to determine the particular need for the local area; and (2) the trial court exceeded the proper scope of review of the hearing officer's decision under the substantial evidence test by reweighing the evidence.

i. Criteria Relating to the Ownership and Management of the Proposed Project

(1) Olathe Hospital Foundation v. Extendicare, Inc. 539 P.2d 1 (Kan. 1975)

Several hospitals brought an action seeking judicial review of a state agency appeals panel's final decision granting a CON to their competitor to construct a new hospital. The applicant, an out-of-state corporation, proposed to operate the new facility through a wholly-owned subsidiary rather than directly. The Court held that the propriety of this arrangement was a matter entrusted to the hospital licensing agencies. When a license for the new hospital is sought the state licensing agency has the authority to require affirmative evidence of ability to comply with reasonable licensure standards and, if the proposed subsidiary cannot furnish such evidence, guarantees could be extracted from the parent corporation or it could be required to operate the hospital itself.

j. Criteria Requiring Joint Planning, Shared Services, Etc.

(1) Lifemark Hospitals of Louisiana, Inc. v. State Dept. of Health and Human Resources No. 250,043 (La. 19th Jud.Dist.Ct. Parish of East Baton Rouge Sept. 21, 1982)

A hospital brought an action seeking judicial review of a DPA decision making findings recommending denial of reimbursement under Section 1122 of a capital expenditure to acquire a CT scanner. The hospital and a competitor had both filed CT scanner applications. Both had been denied for lack of evidence of linkage or sharing of services, a review criterion. The hospitals had refused to enter into a written, formal shared service agreement which was proposed by the DPA. However, the competitor's administrator testified that each hospital would in fact share without a formal agreement if the other acquired the scanner. The Court held that in the absence of a written agreement or a clear and unequivocable commitment to enter into a sharing of scanner services by both facilities, the DPA's determination was not arbitrary or capricious but eminently correct.

k. Criterion Requiring Consistency of Decision to Issue CON With SHP

(1) Statewide Health Coordinating Council v. General Hospitals of Humana, Inc. 660 S.W.2d 906 (Ark. 1983)

Competitors and project opponents brought an action seeking judicial review of a state agency decision granting a CON to Humana to construct a new hospital.

First, Humana asserted that the appeal should be dismissed as moot because during the administrative and judicial proceedings on its application it had entered into a construction contract and commenced actual construction of the project, allegedly for the purpose of complying with the state regulatory requirement that to avoid forfeit the capital expenditure associated with the project must be incurred not more than one year following the date of approval. The Court rejected this argument on the grounds that Humana was not compelled to commence construction at the time it did because: (1) state regulations authorized the applicant to request an extension of the one-year period and Humana did not do so; and (2) it was not necessary for Humana to have entered into the construction contract because state regulations provided that entering into an enforceable contract for financing the project would satisfy the one-year obligation requirement, and Humana had met that requirement by issuing bonds to finance the project within the deadline.

Second, the Court reversed the SHPDA approval, holding that there was no substantial evidence to support the decision because: (1) The State Health Plan's need formula authorized a four beds per 1,000 bed/population ratio with specified exceptions and the SHPDA regulations stated that each state agency decision to issue a CON must be consistent with the SHP, except in emergency circumstances which pose an imminent threat to public health. (2) the addition of the proposed hospital would cause the bed/population ratio in the health service area to exceed the SHP standard, contrary to the principal goals and objectives of the entire federal and state health planning program to reduce the costs of hospital care by prohibiting the construction of new hospitals that would exceed the limit of four beds per 1,000 population; and (3) if, as Humana contended, the federal and state laws were mere guidelines which the director of the State Agency was free to disregard, then the entire federal and state effort to confine the number of hospital beds to the target limitation would be futile, for every agency director would be free to ignore the limitation whenever he saw fit to do so.

(2) *Princeton Community Hosp. v. State Health Planning* 328 S.E.2d 164 (W.Va. 1985)

Two hospitals brought consolidated actions seeking judicial review of state agency decisions denying their applications for bed addition/expansion CONs. The state CON statute contained a set of community need and other CON review criteria resembling the NHPRDA review considerations (42 U.S.C.A. §300n-1(c); Public Health Service Act §1532(c)) and a separate provision requiring that a CON issue only if consistent with the SHP. The SHP contained an acute bed need formula. The state agency denied the applications solely on the basis of inconsistency with the SHP bed need formula.

The Court upheld the state agency's denial of the hospitals' applications, holding that under the state CON statute a project inconsistent with the SHP was required to be denied and, citing *Statewide Health Coordinating Council v. General Hospitals of Humana, Inc.*, *supra*, a determination of inconsistency with the SHP could not be counterbalanced by a favorable finding with respect to other criteria or aspects of the proposal. It rejected the hospitals' argument that denial of a CON based solely on a statistical bed need formula was arbitrary and capricious, holding that the court decisions cited by the hospitals in support of their argument (*Sturmen v. Ingraham*, *Irvington General Hospital v. Dept. of Health*, and *Fairfield Nursing Home v. Whalen*) were inapposite because they did not address the bed need issue within the context of a statutory mandate of SHP consistency. The Court also held that the SHP provisions labeled "Recommended Actions" were in fact requirements, not mere recommendations, because the SHP clearly provided that the recommended actions were chosen to implement SHP objectives and the recommended actions were intended to lend flexibility to the Plan's objectives.

1. Criteria Relating to Access

(1) Chambery v. Axelrod 474 N.Y.S.2d 865 (App.Div. 1984)

A nursing home brought an action seeking judicial review of a SHPDA denial of its application for a bed addition CON. The nursing home historically had a low number of Medicaid admissions. Although it had 42-50% Medicaid patients at the time of application and CON hearing, it had an admissions policy reserving the right to discharge previously private paying patients who became Medicaid-dependent. The application was comparatively reviewed in a "batch" and the application of another nursing home without admission reservations was approved in preference to that of the petitioner.

The Court upheld the SHPDA decision on the grounds that: (1) State regulations set forth as CON review factors, "the current and projected population characteristics of the service area, including relevant health status indicators and socio-economic conditions of the population" and federal regulations (42 C.F.R. §123.412(a)(6)(iii)) provided that a SHPDA reviewing expansion proposals must consider the extent to which the applicant serves Medicaid patients; (2) the vast majority of persons in the applicant's county needing long-term care were Medicaid-dependent; and (3) recognition of the characteristics and socio-economic conditions in the user population to be served, which demonstrated the need for Medicaid-sponsored beds, made the state's decision both logical and reasonable.

(2) Farmworker Rights Organization, Inc. v. Dept of Health and Rehabilitative Services 430 So.2d 1 (Fla. Dist. Ct. App. 1983)

A farmworkers' association brought an action under the state APA seeking a determination as to the validity of the state CON regulatory review criterion on access. The CON criterion did not specifically address the issue of the degree to which medically underserved persons, including low income and minorities, have access to a proposed project, but it did have a general standard requiring consideration of community need. The state CON statute authorized the SHPDA to issue and deny CONs "in accordance with present and future federal and state statutes." (Fla. Stat. §381.494(7)(a) (1981)). NHPRDA requires complying SHPDAs to include among their review criteria consideration of the extent to which the proposed services will be accessible to all residents of the area to be served (42 U.S.C.§300n-1(c)(6)(E)) and implementing federal regulations require SHPDAs to adopt criteria based on specified access standards set forth therein. (42 C.F.R. §123.412(a)(5), (6) and 123.413). The Court struck down the state regulatory review criterion, holding that: (1) in order to be valid under the state CON statute the SHPDA's regulations must be in accordance with NHPRDA and consistent with federal regulations on the same subject; and (2) the state CON regulatory review criterion was inconsistent with federal regulations and consequently not in accordance with NHPRDA since: (i) its criterion for consideration of community need was not broad enough to include consideration of the access criteria mandated by federal regulation; (ii) the SHPDA had no policy of complying with the federal "access" criteria when reviewing every CON application; and (iii) in practice the SHPDA sometimes failed to specifically address the needs of low income and minority persons in CON proceedings.

(3) *Whitehall Boca v. Dept. of Health and Rehabilitative Services* 456 So.2d 928 (Fla.Dist.Ct.App. 1984)

Two nursing homes brought an action seeking judicial review of a state agency decision denying their petitions challenging the validity of the state CON regulatory review criterion on access. One of the nursing homes served only private pay patients; both had CON applications planned or pending. Following the decision in *Farmworker Rights Organization, Inc. v. Dept. of Health and Rehabilitative Services*, *supra*, the SHPDA had amended its CON regulatory review criteria to include an "access" criterion which duplicated with minor changes the CON "access" criteria in 42 C.F.R. §123.412(a)(5), (6) and 123.413, including the provisions for considering the level of indigent care, Medicaid participation, etc. in determining accessibility. The Court held that: (1) The state access criterion did not on its face mandate the taking of private property for public use. Although in application the rule could conceivably result in the denial of an application for a certificate of need in some instances, the constitutionality of that action will be an issue reserved for the happening of that event. (2) The fact that the state access criterion quotes the federal regulation verbatim does not violate state or federal law. Until the SHPDA is able to acquire superior knowledge of economic and minority access needs in particular regions of the state, which obviously can only come about on a case-by-case basis, the state rule is sufficiently specific and the state could not have honed the federal regulations to any greater degree of specificity.

(4) *Collier Medical Center, Inc. v. Dept. of Health and Rehabilitative Services* 462 So.2d 83 (Fla. Dist. Ct. App. 1985), *supra* p. 241.

Consistent Application of Criteria

a. *Cf. Cooper River Convalescent Center, Inc. v. Dougherty* 336 A.2d 35 (N.J.Super.App.Div. 1975)

A nursing home brought an action appealing the denial of its application for a CON to add SNF and/or ICF beds to its facility. The state agency denied the application on the basis of a moratorium on the issuance of CONs for such projects. However, during the time the moratorium was in effect the agency granted a CON to another facility to add SNF beds. The Court upheld the state agency decision, holding among other things that the granting of the CON to the other facility did not deny the plaintiff equal protection because there was a rational basis for excepting the approved facility from the moratorium. The approved facility was the only facility in the state devoted exclusively to serving the elderly blind.

b. North Miami General Hospital, Inc. v. Office of Community Medical Facilities 355 So.2d 1272 (Fla.Dist.Ct.App. 1978)

A hospital brought an action seeking judicial review of a DPA decision recommending denial under Section 1122 of its project to acquire a CT scanner. The DPA denial was based on absence of need measured by a standard which provided that no need was present until existing CT scanners in the area were performing 2,400 scans per year. While the DPA had the hospital's application under consideration, it granted an application to another hospital in the same county to acquire a CT scanner. That decision contained a finding by a hearing officer that the mere fact that other facilities in the area were not all utilized up to the 2,400 scan per year standard was not by itself sufficient to deny a hospital's application as there were reasons for such under-utilization apart from caseload. The Court reversed the DPA decision, holding among other things that the inconsistent results in these two factually similar applications, without a reasonable explanation, indicated that applicant's rights to equal protection under the State and United States Constitutions were violated by the DPA denial.

c. Stamford Hospital v. Commission on Hospitals and Health Care No. 17334 (Conn.Ct.C.P. Fairfield County Jan. 27, 1978)

A hospital brought an action appealing the decision of the state agency denying its application for a CON to acquire a CT scanner. The Court concluded that other hospitals with less need for CT scanners than the applicant had been permitted to acquire them and that this fact rendered the Commission's decision invalid because, even if the Commission was deemed to have the authority to select the most qualified hospitals to receive CT scanners, it did not have the right to deny a scanner to a hospital that was more qualified than one already authorized to acquire one.

d. Texas Health Facilities Commission v. El Paso Medical Surgical Associates 573 S.W. 2d 291 (Tex.Civ.App. 1978)

A medical group which had been granted a CON to establish a day surgery outpatient center brought an action seeking judicial review of a state agency refusal to transfer the CON to a hospital with the center to be relocated in the hospital. State law provided for transfer of a CON prior to completion of the project on good cause as determined by the state agency. The state agency refused to grant the transfer because the proposed facility would be relocated and suggested that the hospital apply for a CON to establish a center. The Court held the state agency did not err in denying the transfer request because: (1) the state CON criteria were "facility-specific" (i.e., a project must be analyzed for consistency with the criteria in the context of the particular parent facility in which it will be located) and a project relocated in a new facility under the CON transfer procedure would circumvent the facility-specific criteria, and (2) the public notice required by law of proceedings to transfer CONs is much shorter than the notice period for a CON application review proceeding, as is the period within which to acquire party opponent status, and therefore allowing a change of location by CON transfer rather than by a new CON application might allow an applicant to utilize the transfer procedure as an avenue to circumvent the full notice requirements and thereby minimize possible opposition.

The applicant also alleged that the state agency erred in failing to follow its established precedent since it had earlier approved a CON transfer involving a relocation. The Court held that the state agency decision was not inconsistent with its earlier approval. That project had possessed a grandfather Certificate of Exemption (COE) which it had acquired without undergoing the usual CON review process. The Court concluded that, because the COE had been acquired without any requirement for review under the "facility-specific" CON criteria, if the certificate of exemption were to be transferred and the location changed the project would still be exempt from review under those criteria. Therefore, no question of circumventing the criteria by means of a certificate transfer had been present in the case of the certificate of exemption transfer approval. As a consequence the two decisions of the state agency were significantly different from each other and not inconsistent with each other.

e. North Charleston Medical Center, Inc. v. South Carolina Department of Health and Environmental Control No. (S.C. County Ct. Charleston County Nov. 21, 1975) reprinted in HOSPITAL FRANCHISING LAW AND REGULATION (A SOUTH CAROLINA CASEBOOK) 369 (1979)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to construct a new facility alleging that the state agency had equal protection by approving similar applications previously. The Court upheld the state agency decision, holding among other things that in order to make out a claim for violation of its rights under the equal protection clause the hospital would have to go beyond showing that some other hospitals were awarded CONs while it was denied and would have to show that another applicant was granted a CON under conditions and circumstances analogous to those existing at the time its application was denied.

f. Hospital of St. Raphael v. Commission on Hospitals and Health Care 438 A.2d 103 (Conn. 1980)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to acquire a CT scanner. The hospital alleged that the Commission's refusal to approve its application denied it equal protection because the Commission had previously approved other scanner applications submitted by hospitals with qualifications and needs allegedly equal to or less than those of the applicant. The Court upheld the state agency decision, holding among other things that the bare fact that certain scanner applications in the past were approved, while the present application was denied, did not approach the required evidentiary burden of proof of purposeful discrimination imposed on a party claiming discriminatory enforcement.

g. Humana Medical Corp. v. State Health Planning and Development Agency 460 So.2d 1295 (Ala.Civ.App. 1984)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to add beds. The application was denied for failure to satisfy the review criteria of "community need" and "cost containment/less costly alternative" on the grounds that there was an area bed supply excess and that better utilization of existing area hospital beds would foster cost containment. The Court upheld the state agency decision, holding among other things that the fact that the SHPDA demanded more or different information from the hospital than it had from other applicants did not constitute a denial of equal protection because: (a) the standard for determining whether there is a violation of equal protection is the "rational relationship" standard, employed where, as here, there is no suspect class involved and no fundamental right in question; (b) cost containment is a legitimate legislative purpose to promote efficient health services; (c) requiring certificates of need to be issued before constructing or enlarging health facilities is certainly rationally related to that purpose; (d) therefore the state's CON review criteria were rationally related to a legitimate legislative purpose and the information required by the SHPDA for the purpose of determining whether the criteria were met was within the SHPDA's discretion.

h. Florida Medical Center v. Dept. of Health and Rehabilitative Services 463 So. 2d 381 (Fla. Dist. Ct. App. 1985)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to acquire a MRI unit. The state agency denied the application on the basis of the following standards: (1) placement of MRI should be limited to research facilities; (2) insufficient knowledge of MRI health risks; (3) lack of financial feasibility since Medicare and private insurance reimbursement, conditioned on as-yet unobtained FDA approval for MRI, was unavailable. The state agency also found no community need since three MRI units were already located in an adjoining area. The state agency had previously approved several MRI applications by other community hospitals without applying the foregoing review standards, but it asserted that the standards constituted new policies properly developed in the course of adjudicating the hospital's application. The Court reversed the state agency and ordered a CON issued to the hospital, holding that the state agency failed to offer a rational explanation why it had applied the standards to the hospital but not to prior applicants.

8. Comparative Review Criteria

a. Introductory Note On Comparative Review Criteria and Standards

Health planning agencies are becoming increasingly involved with comparative reviews of multiple applications for major projects such as construction of new or replacement hospitals. Considerable attention has been focused on the need to adapt and revise CON review procedures designed for review of single applications in order to to accommodate simultaneous review of several competing applications. (See, e.g., Joffe, AN INTRODUCTION TO BATCHING AND COMPARATIVE REVIEWS IN CERTIFICATE OF NEED (Tech.Assist. Memo #58, Western Center for Health Planning, 1981).) However, it is also important to recognize that the function and use of review criteria and standards are different in comparative review.

In a comparative review of truly mutually exclusive applications, only one application (or, in any case, less than all) can be approved consistent with the need criteria. Thus, there are two distinct steps in reviewing each application in a comparative review. First, the project must be reviewed to consider whether it would meet all the relevant criteria if it were the only application being considered. If it does not, it need not be considered further. (See National Nephrology Foundation v. Dougherty, where the Court characterized this initial review as a determination of whether the project was "qualified.") If it does meet all the criteria, considered alone, then it can be reviewed comparatively with all the other "qualified" projects to determine which one best meets the criteria.

It should be apparent that in the course of comparative review the criteria are called upon to serve two different roles: first as fixed, minimum standards, and second as scales or continuums along which relative performance can be measured. (See generally Camhi, et al. CRITERIA AND STANDARDS FOR HEALTH PLANNERS/CONCEPTUAL ISSUES (Technical Assistance Memo #53 Western Center for Health Planning, 1980).) Both applicants and planning agency staff should be alert to this distinction since each will need to address the relationship of the project to the criteria in these two different ways.

In a comparative review applicants and planning agencies have additional tasks not present in a single-application review. The applicant must not only demonstrate the merits of his own project, but also must expose the weaknesses of competing projects. The agency must weigh and balance projects against each other and, importantly, must prepare a final written decision which sets forth the process of reasoning from the evidence to the several decisions to approve one of the competing applications and deny each of the others.

b. Cf. National Nephrology Foundation v. Dougherty 351 A.2d 392 (N.J.Super.App.Div. 1976)

A hospital brought actions appealing the denial of its application for a CON to construct an intermediate renal dialysis facility and the contemporaneous approval of a competitor's application. In upholding the state agency decisions the Court noted that the hospital's application was not rejected because it was not qualified but because the competitors had been found to be the better applicants.

c. Bio-Medical Applications of Greenville, Inc. v. South Carolina Department of Health and Environmental Control No.____ (S.C.Ct.C.P. Greenville County June 13, 1978), reprinted in HOSPITAL FRANCHISING LAW AND REGULATION (A SOUTH CAROLINA CASEBOOK) 401 (1979)

A disappointed competing applicant for a CON to construct a new renal dialysis facility (BMA) brought an action seeking judicial review of its denial and its competitor's (DCI's) approval. The HSA concluded and the state apparently concurred that both applications met the minimum criteria and thus each was "approvable." DCI's application was approved because it offered better back-up arrangements, local support, and prospects for full-time medical staff in residence. BMA argued that since both applications were found to be approvable it should have priority because it had filed its application first. The Court upheld the state agency, rejecting BMA's argument and holding that the final judgment under the law was vested in the state agency which had a legal obligation to make a decision between the competing applicants.

d. Chambery v. Axelrod 474 N.Y.S.2d 865 (App.Div. 1984)

A nursing home brought an action seeking judicial review of a SHPDA denial of its application for a bed addition CON. The nursing home historically had a low number of Medicaid admissions. Although it had 42-50% Medicaid patients at the time of application and CON hearing, it had an admissions policy reserving the right to discharge previously private paying patients who became Medicaid-dependent. The application was comparatively reviewed in a "batch" and the application of another nursing home without admission reservations was approved in preference to that of the petitioner.

The Court upheld the SHPDA decision on the grounds that: (1) State regulations set forth as CON review factors, "the current and projected population characteristics of the service area, including relevant health status indicators and socio-economic conditions of the population" and federal regulations (42 C.F.R. §123.412(a)(6)(iii)) provided that a SHPDA reviewing expansion proposals must consider the extent to which the applicant serves Medicaid patients; (2) the vast majority of persons in the applicant's county needing long-term care were Medicaid-dependent; and (3) recognition of the characteristics and socio-economic conditions in the user population to be served, which demonstrated the need for Medicaid-sponsored beds, made the state's decision both logical and reasonable.

9. State Adoption of Regionalized Service Plan as Prerequisite to Awarding of CON

a. Shoolman v. Health Facilities Appeals Board 413 N.E. 2d 742 (Mass.App. 1980)

A ten-taxpayer group brought an action seeking judicial review of a state agency decision granting a CON to a hospital to construct an ambulatory care center. The taxpayer group alleged that the state agency could not grant a CON in the absence of a regional study demonstrating need for the facility. The Court held that a regional study was not required. The only statutory guideline for defining need was a statement that in making determinations of need the state agency "shall encourage appropriate allocation of private and public health care resources and the development of alternative or substitute methods of delivering health care services so that adequate health services will be made reasonably available to every person within the [C]ommonwealth at the lowest reasonable aggregate cost." The Court was unwilling to read the word "encourage" in this statement to impose an obligation on the Department to make a systematic study prior to a valid grant of a CON.

b. Saint Joseph's Hospital and Medical Center v. Finley 379 A.2d 467 (N.J.Super.App.Div. 1977)

A hospital brought an action seeking judicial review of the decision of the state agency denying its application for a CON to establish a cardiac surgery program. At the time the hospital's application was filed the state agency had not adopted criteria and standards governing cardiac surgery programs. The application was apparently disapproved on the basis of evidence of under-utilization of existing programs in the area, failure of the applicant to consult with other area hospitals, and because the agency did not want to approve any new cardiac surgery programs until it had developed review standards and a carefully organized regional plan for cardiac surgery units. The Court held that the state agency's denial of the application was supported by substantial evidence.

10. Miscellaneous Criteria and Standards Cases

a. Texas Health Facilities Commission v. Baptist General Convention 573 S.W.2d 575 (Tex.Civ.App. 1978)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to add five upper floors to an existing hospital building to be shelled in for later completion according to the needs and growth of the hospital. The state statute and regulations did not contain criteria designed to be used to review applications for construction of shelled-in space but they did contain general criteria relating to, among other things, need, availability of staffing, and financial feasibility. The Court held that the state agency erred in denying the application because the hospital could not be required to commit itself to the specific use to be made in the future of the shelled-in area. The Court observed that the application was for construction of shelled-in space only, and the space would not be used for any purpose without the hospital applying again to the state for approval.

b. North Fulton Community Hospital, Inc. v. State Health Planning and Development Agency 310 S.E.2d 764 (Ga. App. 1983)

A new hospital project proponent brought an action seeking judicial review of a SHPDA decision, affirmed by the State Health Planning Review Board (SHPRD), an administrative appellate panel, denying its application for a CON to construct the new hospital. The hospital alleged, *inter alia*, that the SHPRD erred in basing its decision on both the statutory review considerations and the SHPDS's regulatory review criteria and standards. The Court first held that although the state CON statute provided that the SHPRD should base its decisions on the statutory CON considerations, the SHPRD did not err in also applying the regulatory criteria because other provisions of the CON statute authorized the SHPDA to adopt regulations implementing the considerations and implicit in the interlocking parts of the statutory scheme for CON review was a legislative intent that the SHPRD use the considerations as a base, filling the interstices of the statutory considerations with the agency's rules interpreting and implementing them.

IV. JUDICIAL REVIEW OF CON/1122 DECISIONS

A. PROCEDURAL ASPECTS OF JUDICIAL REVIEW OF CON/1122 DECISIONS

1. Section 1122 jurisdictional issues

a. Availability of Relief by Way of Judicial Review

(1) Availability of relief by way of state court judicial review of DPA decisions.

(A) Review not available

(i) Palmetto General Hospital v. State Dept. of Health and Rehabilitative Services 333 So.2d 531 (Fla. Dist.Ct.App. 1976)

A hospital brought an action seeking judicial review of a DPA decision denying its project to complete a partially constructed hospital an exemption from Section 1122 review. The hospital asserted that it was exempt from review by virtue of the Section 1122 grandfather clause (Section 221(d) of P.L. 92-603 [not codified]; 42 CFR §100.103). The Court declined to review the DPA decision on the grounds that any ruling it might make on the exemption would not be binding on the Secretary of HHS.

(ii) Bureau of Community Medical Facilities v. Samson 341 So.2d 1071 (Fla.Dist.Ct.App. 1977)

A DPA brought an action seeking judicial review of the decision of a hearing officer reversing the DPA's recommendation of denial of reimbursement under Section 1122 of a project to construct a new hospital. The state's Section

1122 contract required the DPA to comply with the federal Section 1122 regulations including providing disappointed applicants with a fair hearing before a hearing officer whose decision superseded the findings and recommendations of the DPA (42 CFR §100.106(c)(2), (4) (1976)). However, the state APA secured judicial review only of "final agency action." The Court held that judicial review of the hearing officer's decision was not available because the hearing officer's decision technically could not be the final agency action. The DPA must take the final action after the hearing officer's decision by either recommending denial or approval. If the DPA recommends denial it violates its 1122 contract, the Court observed. And if it recommends approval it will then lack standing to seek judicial review as a "person adversely affected."

(iii) Sarah A. Todd Memorial Home v. Commonwealth Department of Health 410 A.2d 405 (Pa.Cmwlth. 1980)

A nursing home brought an action appealing a hearing officer's decision affirming a proposed negative recommendation by the DPA under Section 1122 of its application to construct a new nursing home. The Court held that it lacked jurisdiction to review the decision because it was not a final administrative agency determination. The Court reasoned that if the action were viewed as an appeal from a hearing examiner, it was clear that the requirement of administrative agency action was lacking. Viewed as an appeal from a proposed negative recommendation from the DPA to the Secretary of HHS, the necessary requisite of finality was absent.

(iv) Mallard Associates v. Commonwealth Department of Health 422 A.2d 1178 (Pa.Cmwlth. 1980) ("Mallard I")

A nursing home brought an action seeking judicial review of a hearing examiner's affirmance of a DPA decision making findings recommending denial of reimbursement under Section 1122 for its project to construct a new facility. The Court: (1) followed Sara A. Todd Memorial Home, supra, on the jurisdictional issue, and (2) rejected the nursing home's argument that the federal 1122 regulations (specifically, 42 C.F.R. §100.106(c)(4) which provides that, "where judicial review of [a hearing examiner's decision on an 1122 application] is obtained, the final decision of the reviewing court...shall...supersede the findings and recommendations of the [DPA]) required judicial review of DPA decisions, ruling that the federal regulations merely provide procedural rules that apply in the event judicial review is required by state law.

(v) Greenbriar Convalescent Center, Inc. v. Department of Public Health 310 N.W.2d 812 (Mich.App. 1981)

A nursing home brought an action seeking judicial review of a DPA decision that its proposed construction project did not fall within the Section 1122 grandfather exemption. Review was sought under a state statute providing for judicial review of state agency "rulings" as to the applicability of a statute "administered by the agency" to an actual state of facts. The Court held that a DPA determination of non-exemption from the Section 1122 review process was not reviewable under the state statute because: (1) the federal 1122 regulations do not expressly provide for judicial review of determinations of non-exemption, instead providing that such determinations may be appealed to the Secretary of HHS (42 CFR §100.103(d)), and where the federal regulations intend to make provision for state judicial review of DPA determinations they do so explicitly. [See e.g., 42 CFR §100.106(c)(4), which permits state court review of DPA determinations on the merits of proposed capital expenditures]. (2) Section 1122 review is a federal program administered by DHHS. Although the DPA has a contractual role in the program, it is not "administered" by the DPA, and therefore its determinations of non-exemption are not covered by the state judicial review statute. (3) Citing Palmetto General Hospital Inc. v. State Department of Health and Rehabilitative Services, the Court also observed that in the absence of authorization for state court judicial review in the federal 1122 statute or regulations it was extremely doubtful whether the Secretary of HHS would be bound to follow a state court judgment.

(vi) Mallard Associates v. Commonwealth Department of Public Health 439 A.2d 866 (Pa.Cmwlth. 1982) ("Mallard II")

A nursing home brought an action seeking review by way of a writ of mandamus of a hearing officer's affirmance of a DPA decision recommending denial of reimbursement under Section 1122 of the nursing home's project to construct a new facility. The Commonwealth Court had original jurisdiction in actions of mandamus to review ministerial, non-discretionary acts of state agencies and appellate jurisdiction to review discretionary final orders of state agencies. In Mallard I, supra, the Court denied this petitioner appellate review for want of jurisdiction, because, viewed as an appeal from a hearing officer's decision, the action lacked the element of agency action and, viewed as an appeal from DPA recommendation to DHHS, finality was absent. In this case, Mallard II, the Court held that it lacked original jurisdiction as well because: (1) the hearing officer, being a creature of federal statute and regulation, was neither an officer nor an agency of the state; and (2) petitioner's action sought review of discretionary, not ministerial, acts. [Compare Citizens General Hospital v. Commonwealth Department of Health, infra, holding that an action in preemptory mandamus directed at the Court's original jurisdiction was maintainable, where the relief sought was an order that the 1122 project be "deemed approved" for failure of the DPA to timely disapprove.)

(vii) Lifemark v. Guissinger 446 So.2d 1279 (La. 1982)

A hospital brought an action seeking judicial review of a DPA decision making findings recommending approval under Section 1122 of its competitor's project to construct a new hospital and judicial review of the DPA decision recommending denial of its own similar project. The federal Section 1122 statute and regulations (which the state 1122 regulations repeated) required the DPA to grant to a person proposing a capital expenditure the right to an administrative appeal, which right must be exercised within 30 days after the date on which the person proposing the capital expenditure receives notice of an adverse finding or recommendation. (42 U.S.C.A. §1320a-1(b)(3); 42 CFR §§100.106(c), (c)(1)).

The Court dismissed the action, holding among other things that the hospital was not entitled to bring an action opposing the 1122 approval of its competitor because the federal law and regulations did not require establishment of appeal procedures for opponents of proposals that have been approved and the state had not chosen to establish appeal rights for opponents.

(viii) Rapides General Hospital v. Robinson No. 280, 043 (La. 19th Jud.Dist.Ct. Parish of East Baton Rouge, Aug. 9, 1984)

Two hospitals brought an action seeking judicial review and the setting aside of a DPA decision which made findings recommending approval under Section 1122 of their competitor's project to construct a new hospital. Plaintiffs' Section 1122 applications had been denied and their competitor's application was pending on the date on which the DPA, pursuant to the order of the Governor, imposed a moratorium on issuance of DPA decisions making findings and recommendations under Section 1122. The Governor's order commanded the DPA to exclude the competitor's project from the moratorium and to make findings approving it. Citing Lifemark v. Guissinger, the Court dismissed the action holding that plaintiffs were not entitled to seek judicial review of their competitor's 1122 approval. The Court rejected the argument that Lifemark was distinguishable because plaintiffs therein sought judicial review of the merits of an 1122 approval issued by proper procedure while in this case the 1122 approval was issued pursuant to a gubernational order that was an ultra vires action beyond the Governor's authority. The Court held that the DPA's approval of the competitor's application was not the result of an ultra vires action because the DPA was an agency of the executive branch serving under the direction and authority of the Governor.

(ix) Cf. Psychiatric Institutes of America, Inc. v. Heckler 596 F.Supp. 1311 (E.D.La. 1984), infra p. 266.

(x) State ex rel. Pilot Development Northwest, Inc. v. State Health Planning and Development Bureau 701 P.2d 390 (N.M. App. 1985)

A nursing home (Pilot) brought an action in mandamus seeking a court order declaring void the DPA's decision recommending approval of its competitor Americare's bed construction project pursuant to a settlement negotiated during an administrative appeal between the DPA and Americare. Americare brought an action appealing the 1122 hearing officer's dismissal of its administrative appeal of the DPA's favorable recommendation of Pilot's project. The actions were consolidated on appeal.

Pilot had applied for approval of 90 ICF beds. Americare applied initially for 84 ICF/36 SNF. The SHP showed a need for 90 ICF. The applications were batched. The DPA decision approved Pilot's application and denied Americare. By this time the SHP need had grown to 162 ICF. Americare was granted an administrative appellate fair hearing on its denial and Pilot's approval. While the hearing was pending, Americare negotiated a settlement with the DPA under which its administrative appeal was dismissed and the DPA agreed to approve its application as amended to 72 ICF/24 SNF/24 personal care beds not subject to 1122 review. Pilot responded with its mandamus action. When the trial court issued a writ of mandamus declaring the settlement void, invalidating Americare's amendment of its application during appeal, and ordering the amended application reviewed anew, Americare attempted to reinstitute its administrative appeal. When the hearing officer rejected its attempt, Americare brought its appeal.

First, the Court dismissed Americare's appeal, holding that Americare had no right to appeal the 1122 hearing officer's decision because neither Section 1122 law and regulations nor any state statute provided such a right to appeal.

Second, the Court upheld Pilot's mandamus action. It held that the courts did have the authority to review DPA actions by way of a mandamus action because: (1) the courts had jurisdiction to hear the writ petition under a state statute authorizing issuance of the writ to compel the performance of ministerial acts imposed by law on public officials; and (2) Pilot had no adequate remedy of appeal since no statute authorized an appeal.

(B) Review available

(i) *Charter Medical Corporation v. Mississippi Health Planning and Development Agency* 362 So.2d 180 (Miss. 1978)

A hospital brought an action seeking to enjoin a DPA decision denying reimbursement under Section 1122 of a project to acquire a CT scanner. The Court held that such relief was available, ruling that the fact that a decision on review would not be binding on the Secretary of HHS (who has limited authority under 42 U.S.C.A. §1320a-1(f) to override a DPA 1122 disapproval) did not mean that state courts could not review a DPA decision to ascertain whether it was supported by substantial evidence.

(ii) *Lynch Medical Services, Inc. v. State Comprehensive Health Planning Council* 27 K.L.S.9 (Ky.Ct.App. May 16, 1980); [1981 Transfer Binder] Medicare and Medicaid Guide ¶31,455

A competitor brought an action to enjoin the DPA from recommending approval for reimbursement under Section 1122 of a project to construct a primary care center. Following *Charter Medical*, *supra*, the Court held that such relief was available, holding in addition that the competitor/appellant had exhausted all avenues of administrative review available at the state level and its failure to request a reconsideration by the Secretary of HHS of his decision on the project did not constitute a failure to exhaust administrative remedies.

(iii) *Citizens General Hospital of New Kensington, Pennsylvania v. Commonwealth Department of Health* 430 A.2d 393 (Pa.Cmwlth. 1981)

A hospital brought an action seeking an order directing the DPA to "deem approved" its application for reimbursement under Section 1122 of a capital project. The DPA had declared the project complete, prepared a proposed negative recommendation to the Secretary of HHS, and rejected the hospital's arguments that the project should be deemed approved for failure of the DPA to timely disapprove (*See* 42 CFR §100.106(a)(4)). These DPA actions had been *upheld* in administrative appeals brought by the hospital. The hospital had then unsuccessfully attempted to appeal the disapproval on the merits to Court, but the Court had refused to hear the appeal on the authority of *Sarah A. Todd Memorial Home v. Department of Health*, *supra*. The hospital then brought this action. The Court held that the hospital could maintain the action because: (1) it exhausted its administrative appeal remedies (compare *Canonsberg General Hospital v. Department of Health*, *infra*); (2) the holding in *Sarah A. Todd* was not a bar because the hospital was not appealing the negative recommendation itself but instead seeking to have the application deemed approved; and

(3) it was not required to have pursued its federal administrative remedy of seeking a reconsideration of a determination by the Secretary of HHS (Section 1122(f), 42 USCA §1320a-1(f)) because the action was brought to require the state to deem the application approved, not to review a decision by the Secretary of HHS.

(iv) Heritage Regency, Inc. v. State Board of Health of Indiana as the Designated Planning Agency
No. C-80-9441-C (Indiana Cir.Ct. Wayne County May 21, 1981)

A hospital brought an action seeking judicial review of a DPA decision making findings recommending denial of reimbursement under Section 1122 for a "comprehensive care" (nursing care) facility. The hospital petitioned for judicial review under the state Administrative Procedures Act (APA) which provides for judicial review of final state agency decisions on the petition of aggrieved parties. The Court held that it had jurisdiction to review the DPA recommendation because: (1) the DPA was a "state agency" under the state APA, not a federal agency, (2) the facility was a party aggrieved by a DPA decision because the state agency conduct caused the alleged aggrievement and, if relief from any aggrievement were forthcoming, it would have to happen at the state court level (because Section 1122(f) barred judicial review at the federal level), and (3) the DPA findings and recommendation to the Secretary constituted a final agency decision because they ended the proceedings at the state level and the Secretary's authority to overturn them was limited. The Court thus determined that review was available even though judicial review of 1122 decisions was not provided for by state statute, rejecting the reasoning of Mallard I and Sara A. Todd Memorial Home v. Commonwealth Department of Health.

(v) State ex rel. Pilot Development Northwest, Inc. v. State Health Planning and Development Bureau 701 P.2d 390 (N.M. App. 1985)

A nursing home (Pilot) brought an action in mandamus seeking a court order declaring void the DPA's decision recommending approval of its competitor Americare's bed construction project pursuant to a settlement negotiated during an administrative appeal between the DPA and Americare. Americare brought an action appealing the 1122 hearing officer's dismissal of its administrative appeal of the DPA's favorable recommendation of Pilot's project. The actions were consolidated on appeal.

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(2) Availability of relief by way of federal court judicial review of DPA decisions

(A) Review not available

(i) Wilmington United Neighborhoods v. United States 615 F.2d 112 (3d Cir. 1980), cert. den., 449 U.S. 827 (1980)

Consumers of medical services sought judicial review of a DPA decision approving for reimbursement under Sec. 1122 a project to relocate hospital services from the inner city to suburban Wilmington. Review was sought on the grounds that the DPA approval was inconsistent with applicable standards, criteria, and plans and that the DPA violated certain of its obligations under Section 1122. The Court held that Section 1122(f) impliedly precluded judicial review of DPA determinations such as those complained of, on the grounds that judicial review would interfere with the autonomy or authority of state and local health planning agencies and that it would be incongruous for Congress to have provided for judicial review of DPA 1122 decisions while precluding review of 1122 decisions by the Secretary of HHS.

(ii) Psychiatric Institutes of America, Inc. v. Heckler 596 F.Supp. 1311 (E.D.La. 1984)

PIA brought an action seeking to permanently enjoin DHHS from making a favorable determination of reimbursement under Section 1122 for a competitor's psychiatric hospital construction project during the pendency of PIA's action in state court seeking judicial review of the DPA hearing officer's decision approving the project. PIA and the competitor had received 1122 approval for psychiatric hospital construction but neither had built. The Court held that PIA was not entitled to an injunction because: (1) PIA could not show that DHHS would violate any law by making a favorable determination based on the hearing officer's favorable decision because: (a) PIA was not entitled to state or federal court review of the hearing officer's decision since Section 1122 did not give nonapplicants the right to challenge a favorable state finding in state or federal court (citing Hollingsworth v. Schweiker, Wilmington United Neighborhoods v. U.S., and Lifemark v. Guissinger; (b) the DPA hearing officer's decision would therefore necessarily serve as the final state finding on which DHHS' determination would be based; and (c) consequently, DHHS' favorable determination based on the hearing officer's favorable decision prior to the resolution of PIA's state court action would not violate any law; (2) PIA could not show that it would be irreparably harmed if an injunction did not issue because it would be mere speculation to assume that the future establishemnt of the competitor's facility would injure its unbuilt facility; and (3) PIA could not show that it lacked an adequate remedy at law because it had the right under Section 1122(f) to request reconsideration by the Secretary of her initial 1122 determination. The court also held that PIA could not obtain judicial review until it exhausted its administrative remedy of requesting reconsideration.

(B) Review available

(i) Lakeside Mercy Hospital v. Indiana State Board of Health 421 F.Supp. 193 (N.D.Ind. 1976) aff'd without published opinion 547 F.2d 1170 (7th Cir. 1976)

A corporation formed to establish a hospital brought an action seeking a declaratory judgment that its application for reimbursement under Section 1122 of a project to construct a new facility should be "deemed approved." Because it had been enjoined from acting on applicant's proposal by a state court, the DPA failed to provide applicant with notification of its rejection within the time limitations prescribed by federal 1122 regulations. Federal regulations provide that failure to provide timely notification is deemed an approval (42 CFR §100.106(a)(4)). The Court agreed to consider applicant's claims, holding that the case involved a substantial federal question concerning the construction of a federal statute (Section 1122), and that accordingly there was jurisdiction under 28 U.S.C.A. §1331. The 1122(f) preclusion of review issue was not addressed by the Court.

(ii) *First Federal Savings and Loan Association of Lincoln v. Casari* 667 F.2d 734 (8th Cir. 1982) *cert.den.*, 458 U.S. 1106 (1982)

A corporation brought an action seeking to enjoin the DPA from recommending denial of reimbursement under Section 1122 of its project to acquire and reopen a nursing home. The corporation argued that the DPA lacked authority to conduct 1122 reviews because it had failed to adopt certain rules implementing its 1122 contract. The Court held that such a claim substantially alleged a federal question, following *Lakeside Mercy Hospital, supra*. The Court also held that, assuming *arguendo* that Section 1122(f) bars judicial review of determinations by the DPA under Sec. 1122, 1122(f) does not bar review of issues such as whether the DPA has complied with enabling-type provisions and whether it has authority to act. *Compare Hollingsworth v. Harris*.

The DPA also alleged that the action was barred by the Eleventh Amendment to the U.S. Constitution which prohibits suits in federal courts against an unconsenting state by its own citizens. The Court held the action was not barred by the Eleventh Amendment because it sought equitable relief only and the relief requested would not have any impact upon the state treasury.

(iii) *Humana Medical Corp. v. Schweiker* No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. On November 24, 1970 the hospital had acquired an adjacent facility with a view toward expanding its existing plant. On December 21, 1972 it applied for a CON for a 55 bed expansion/renovation project on the site. On December 29 or 30, 1972 the hospital poured a concrete footing for a construction project on the site. On April 15, 1973 it received a CON for the project, valid for six months and showing an estimated cost of $750K. On Sept. 26, 1973 it entered into a construction contract for Phase I of the project. Following completion of Phase I the hospital entered into a contract for Phase II on July 1, 1974 at a stated cost of $1.6M. Phase II was completed in July 1976 at a total project cost of $3.3M.

On October 30, 1972 Congress had passed P.L. 92-603, which adopted the Section 1122 program and which contained a provision (the so-called "221(b) effective date") stating that the Section 1122 program would apply only with respect to capital expenditures incurred subsequent to the earlier of December 31, 1972 or the last day of the calendar quarter in which a State requested that the program apply (P.L. 92-603 §221(b) not codified; See 42 U.S.C.A. §1320a-1 Historical Note). Federal regulations provide for coverage under Section 1122 of capital expenditures incurred after December 31, 1972 or the effective date of a DPA Agreement, whichever is later, and permit the Agreement's effective date to be earlier than its signing date if DPA procedures utilized as of the earlier date satisfy DHHS (42 CFR §100.103). The Alabama DPA issued an 1122 Procedures Manual effective September 18, 1973 and on February 27, 1974 the state entered into a DPA Agreement with DHHS, antedated to Sept. 18, 1973, eight days before the hospital's Phase I contract.

In late 1976 Medicare fiscal intermediary auditors warned the hospital that under Section 1122 it would not be able to receive reimbursement for capital costs associated with the costs in excess of the amount on the April 1973 CON for the project without DPA approval. In response the hospital applied for and received DPA approval on March 21, 1977 of the costs in excess of $750K. In January 1977 DHHS had issued a Policy on Lack of Timely Notice (Section 1122 Notice 77-01; 42 Fed. Reg. 4847 (January 26, 1977); 42 CFR §100.108 Note (1981)) providing that when a person neglects to submit an 1122 application within 60 days prior to incurring a capital expenditure as required by Section 1122 DHHS will withhold reimbursement for one year. Pursuant to the policy, at the DPA's recommendation the Secretary of DHHS decided to exclude reimbursement for one year on the costs in excess of the amount on the original CON. The hospital requested and was denied a fair hearing on the one-year exclusion by the DPA. When the fiscal intermediary denied reimbursement on account of the DHHS exclusion, the hospital appealed the denial to the PRRB (the Medicare administrative appeals board) and, following the PRRB's refusal to take jurisdiction on the question of the propriety of the Secretary's exclusion, brought this action.

The hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc. In the first of several preliminary rulings on jurisdictional issues, the Court held that Section 1122(f) (42 U.S.C.A. §1320a-1(f)), which prohibits administrative or judicial review of 1122 determinations by the Secretary of DHHS, withdrew the Court's authority to review any substantive determinations by the Secretary but did not bar it from reviewing under federal question jurisdiction issues involving whether the

DPA followed the required procedures, whether the DPA had the authority to review the project under 1122, and any constitutional challenges to the statute or regulations.

Next, the Court dismissed the hospital's complaint against the state defendants (the state governor and health department director), holding that the hospital failed to state a claim upon which relief can be granted against them because: (a) money damages against them in their official capacities are barred by the Eleventh Amendment and are barred against them in their individual capacities by the fact that they were not in office at the time of, or not involved in, the DPA actions complained of; and (b) declaratory and injunctive relief against the State and its officials cannot be granted because Alabama no longer participates in the 1122 program. Concluding that any procedural or other errors made by the state defendants could be rectified by ordering the remaining defendant DHHS to take appropriate steps, the Court reached the merits of the hospital's claims against the DPA. It held as follows: (1) The hospital asserted that the obligation for all the capital expenditures associated with the project was incurred on Sept. 26, 1973, when the Phase I contract was signed, and that the DPA lacked authority to conduct an 1122 program on that date because, although the DPA Agreement was later antedated to September 18, 1973, there was no signed DPA Agreement on September 26. The Court rejected this argument, holding that: (a) as long as the DPA satisfied 1122 requirements and the hospital was actually notified of the state's inception of 1122 review, antedating the DPA Agreement pursuant to 42 CFR §100.103 was not improper because the signing of a DPA Agreement was not an authorization to set up an 1122 program but rather an approval that all requirements had been met, all procedures were in place, and review of capital expenditures was proceeding according to the statute; and (b) the "221(b) effective date provision" did not require dating the DPA Agreement on the last date of the calendar quarter in which the Agreement was signed because 221(b) only operated to set the effective date for states which sought to implement 1122 prior to December 31, 1972; and (c) 42 CFR §100.103, which sets the effective date of 1122 programs entered into after December 31, 1972, was not arbitrary, capricious or an abuse of discretion. (2) The project was not exempt on the grounds that construction began in December 1972 before the effective dates of the federal 1122 statute and the state program because the pouring of the concrete footing could not be construed as a start of construction (particularly where the hospital changed the architect and general contractor between then and the Phase I contract) but rather as a sham performed in an attempt to avoid the 1122 requirements. (3) The Court held that the DPA was not required under Section 1122(b) (42 U.S.C.A. §1320a-1(b)) to provide the hospital with a "fair hearing" on the question of whether the DPA received timely notice because: (a) the statute requires a DPA hearing only on a finding that the project is inconsistent with the review criteria; (b) the 1122 regulations, which are entitled to judicial deference, do not provide for a hearing on timely notice (42 CFR §100.106(a)(4)(iii)); and (c) DHHS, not the DPA, determines whether timely notice was given.

(3) Availability of relief by way of federal court judicial review of Secretary of HHS's decision

(A) Review not available

i. Chalmette General Hospital, Inc. v. Secretary of Health, Education, and Welfare No. 78-309 (E.D.La. Mar. 14, 1978)

A competitor hospital brought an action seeking declaratory and injunctive relief and judicial review of determinations of the Secretary of HHS relating to the approval for reimbursement and extension of time to secure financing for their competitor's project to construct a new hospital. The Court dismissed the complaint, holding that because Section 1122(f) barred review of determinations of the Secretary no federal question jurisdiction (28 U.S.C.A. §1331) arose under Section 1122. The Court also held that the federal APA and the Declaratory Judgment Act (28 U.S.C.A. §2201) did not provide a jurisdictional basis.

ii. Wilmington United Neighborhoods v. United States 615 F.2d 112 (3rd Cir. 1980), cert.den., 449 U.S. 827 (1980)

Consumers of medical services sought judicial review of various substantive and procedural decisions made by the Secretary of HHS in the course of his decision approving for reimbursement under Section 1122 a project to relocate hospital services from the inner city to suburban Wilmington. The Court held that Section 1122(f), which provides that "(a) determination by the Secretary under this section shall not be subject to administrative or judicial review" (42 USCA §1320a-1(f)), unequivocally barred review of any determination by the Secretary including decisions by the Secretary as to the scope of his review of the state DPA approval of the project and decisions as to the necessity of repeating the review process after the project had undergone modifications.

iii. Luzerne County Medical Society v. Harris No. 78-1181 (M.D.Pa. June 13, 1980)

A medical society brought an action seeking declaratory and injunctive relief to stop the Secretary of HHS from approving, or acquiesing in the DPA approval for reimbursement of, an extension of time to secure financing for and an increase in the cost of a project previously approved under Section 1122 to construct a hospital. The Court held that the matters sought to be reviewed were "determinations" by the Secretary, and thus precluded from review by Section 1122(f), citing Wilmington United Neighborhoods, supra.

(iv) Humana Medical Corp. v. Schweiker No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. The factual background of the case is described in the annotation to Humana Medical Corporation v. Schweiker at p. 267, supra.

The hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc. In the first of several preliminary rulings on jurisdictional issues, the Court, citing Hollingsworth v. Harris, held that Section 1122(f) (42 U.S.C.A. §1320a-1(f)), which prohibits administrative or judicial review of 1122 determinations by the Secretary of DHHS, withdrew the Court's authority to review any substantive determinations by the Secretary but did not bar it from reviewing under federal question jurisdiction issues involving whether the state and federal governments followed the required procedures, whether the DPA had the authority to review the project under 1122, and any constitutional challenges to the statute or regulations. Thus, the Court concluded that 1122(f) barred review of the Secretary's determination that the hospital's project was not exempt from review under the 1122 grandfather clause (which exempts capital expenditures which the facility had committed itself to and spent $100K on prior to December 18, 1970 [P.L. 92-603 §221(d) not codified, 42 U.S.C.A. §1320(a)-1 Historical Note]). The Court also concluded that 1122(f) precluded its review of the Secretary's determinations as to the parts of the project which were expenditures for which timely notice should have been given, and whether such notice was given. The Court held that 1122(f) did not bar judicial review of the propriety under the federal APA of the Secretary's informal promulgation of the Policy on Lack of Timely Notice. Next, the Court held that the federal courts' mandamus jurisdiction (28 U.S.C.A. §1361) did not constitute an exception to the jurisdictional bar of 1122(f) because 1122(f) was passed after §1361 and, since a court with mandamus jurisdiction is limited to reviewing nondiscretionary, non-substantive agency decisions, mandamus jurisdiction would not allow review of anything not also permitted under the Hollingsworth rule.

The Court then held that the general rule of law that a jurisdictional withdrawal statute like 1122(f) never bars jurisdiction over a claim that an agency exceeded statutory authority did not give the court any additional jurisdiction to review DHHS' decisions because the hospital's remaining objections went to the merits of the Secretary's decisions, not his power to decide. Finally, the Court held that it did not have jurisdiction to review the Secretary's 1122 determinations by way of its jurisdiction to review PRRB decisions because 1122(f) barred PRRB review of the Secretary's determinations.

(B) Review available

(i) Hollingsworth v. Harris 608 F.2d 1026 (5th Cir. 1979), rev'g., 477 F.Supp. 872 (N.D.Miss. 1979)

An existing nursing home brought an action seeking judicial review of the Secretary of HHS's approval for reimbursement under Section 1122 of its competitor's project to construct a nursing home. The petitioner alleged that the Secretary failed to observe its own procedures in passing on the competitor's project. The District Court dismissed the action in part on the grounds that Section 1122(f) precluded review. The Fifth Circuit held that although Section 1122(f) withdrew federal court jurisdiction to review "determinations" by the Secretary, judicial review was available where the federal administrative agency was alleged to have failed to follow the procedures outlined in its regulations. Compare First Federal Savings and Loan of Lincoln, supra.

(ii) Humana Medical Corp. v. Schweiker No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. The factual background of the case is described in the annotation to Humana Medical Corp. v. Schweider at p. 267, supra.

The hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc. In the first of several preliminary rulings on jurisdictional issues, citing Hollingsworth v. Harris, the Court held that Section 1122(f) (42 U.S.C.A. §1320a-1(f)), which prohibits administrative or judicial review of 1122 determinations by the Secretary of DHHS, withdrew the Court's authority to review any substantive determinations by the Secretary but did not bar it from reviewing under federal question jurisdiction issues involving whether the federal government followed the required procedures and any constitutional challenges to the statute or regulations. Thus, the Court concluded that 1122(f) barred review of the Secretary's determination that the hospital's project was not exempt from review under the 1122 grandfather clause (which exempts capital expenditures which the facility had committed itself to and spent $100K on prior to December 18, 1970 [P.L. 92-603 §221(d) *not codified*, 42 U.S.C.A. §1320(a)-1 *Historical Note*]). The Court also concluded that 1122(f) precluded its review of the Secretary's determinations as to the parts of the project which were expenditures for which timely notice should have been given, and whether such notice was given. Also applying *Hollingsworth*, the Court held that 1122(f) did not bar judicial review of the propriety under the federal APA of the Secretary's informal promulgation of the Policy on Lack of Timely Notice. Next, the Court held that the federal courts' mandamus jurisdiction (28 U.S.C.A. §1361) did not constitute an exception to the jurisdictional bar of 1122(f) because 1122(f) was passed after §1361 and, since a court with mandamus jurisdiction is limited to reviewing nondiscretionary, non-substantive agency decisions, mandamus jurisdiction would not allow review of anything not also permitted under the *Hollingsworth* rule. The Court then held that the general rule of law that a jurisdictional withdrawal statute like 1122(f) never bars jurisdiction over a claim that an agency exceeded statutory authority did not give the court any additional jurisdiction to review DHHS' decisions because the hospital's remaining objections went to the merits of the Secretary's decisions, not his power to decide. Finally, the Court held that it did not have jurisdiction to review the Secretary's 1122 determinations by way of its jurisdiction to review PRRB decisions because 1122(f) barred PRRB review of the Secretary's determinations.

(iii) *Huron Valley Hospital, Inc. v. City of Pontiac* 585 F.Supp 1159 (E.D. Mich. 1984) ("*Huron v. Pontiac* II")

Proponents of a new hospital construction project (HVH) brought an action seeking judicial review of a DHHS administrative decision to withhold reimbursement under Section 1122 for capital costs associated with the project.

The Court issued a writ of mandamus ordering DHHS to reinstate HVH's Section 1122 approval (*see Huron v. Pontiac II*, *supra*). The Court held that: (1) Section 1122(f) did not foreclose judicial review of DHHS's decision because Section 1122(f) only precludes review of the two determinations by DHHS specified in 1122(d) - the determination regarding lack of timely notice and the determination in a situation where the state DPA has made a negative finding - and neither of these determinations occurred in this case; and (2) DHHS lacked authority to render its decision in this case because the two 1122(d) determinations are the only determinations the Secretary can make under Section 1122. The Court rejected DHHS's argument that its decision merely implemented its duty to determine that the DPA approval followed the proper procedures, citing Hollingsworth v. Schweiker for the proposition that the only procedure for DHHS to consider in a case where a state DPA has issued a positive recommendation is whether or not the timely notice requirement was met by the project proponent.

(iv) Humana Hospital Corp., Inc. v. Blankenbaker 734 F.2d 328 (7th Cir. 1984)

Humana brought an action in federal court seeking to enjoin submission to DHHS of a DPA decision, affirmed by a state hearing officer, recommending denial of reimbursement under Section 1122 of its project to construct a new hospital. Humana alleged that the DPA had failed to follow various procedural requirements of federal 1122 regulations and that the DPA's decision was not supported by substantial evidence. The Court held that the complaint should be dismissed for lack of jurisdiction due to Humana's failure to exhaust its administrative remedies of DHHS determination of reimbursement and DHHS reconsideration. The Court noted, citing Hollingsworth v. Harris, that Humana would not be barred from seeking judicial review of the further DHHS administrative actions by Section 1122(f), which provides that DHHS determinations under 1122 shall not be subject to administrative or judicial review, because judicial review of the Secretary's compliance with the procedures of Section 1122 and the regulations thereunder is not barred by Section 1122(f).

(v) Health Quest Corp. v. Ellis No. IP83-1046-C (U.S.D.C., S.D. Ill. July 12, 1984), CCH, MEDICARE & MEDICAID GUIDE ¶ 34,176.

A nursing home corporation brought an action seeking mandamus to compel DHHS to certify as eligible for reimbursement the capital costs associated with two projects reviewed in 1978 under Section 1122 for construction of nursing homes. The DPA had initially prepared a negative recommendation respecting each project on the grounds of inconsistency with the "Bed Guide", an unpublished review criterion. In one case a fair hearing officer reversed the negative recommendation on the ground that the Bed Guide was an invalid criterion because it had not been promulgated as a regulation under the state APA. In the other case a state court vacated the DPA decision on the same legal ground. In both cases the DPA then submitted a favorable recommendation to DHHS. DHHS refused to reimburse, reasoning that the decisions of the hearing officer and state court did not reverse or modify the initial DPA decisions that the projects were inconsistent with the Bed Guide; that state law should not have been used to void the Bed Guide; and that, using federal law, the Guide was valid and should be used to deny the applications.

The Court issued the writ, holding among other things that Section 1122(f) did not bar it from granting relief because: (a) 1122(f) did not bar jurisdiction to determine whether the Secretary had followed statutory requirements (*citing Hollingsworth v. Harris* and *Humana Hospital Corp. v. Blankenbaker*; (b) mandamus falls outside the ban on judicial review because it is an extraordinary writ proceeding, not judicial review; and (c) 1122(f) prohibits judicial review of the Secretary's "determinations" and DHHS' unauthorized finding in this case that reimbursement should be denied despite the state's approval was not a "determination" under 1122(f).

b. Standing to Obtain Judicial Review

(1) Competitors

(A) Competitors granted standing

i. *Lynch Medical Services, Inc. v. State Comprehensive Health Planning Council* 27 K.L.S.9 (Ky.Ct.App. May 16, 1980); [1981 Transfer Binder] *Medicare and Medicaid Guide* ¶31,455

A competitor brought an action to enjoin the DPA from making findings recommending approval for reimbursement under Section 1122 of a project to construct a primary care center. The Court held that the plaintiff had standing to seek judicial review because: (1) the plaintiff's license as a primary care center charged it with the responsibility of attending to the medical welfare of the public in its geographic area (which included the area the project proposed to serve), and (2) the issues in the case involved the proper expenditure of public funds.

ii. *Hollingsworth v. Harris* 608 F.2d 1026 (5th Cir. 1979), *rev'g.*, 477 F.Supp. 872 (N.D.Miss. 1979)

An existing nursing home brought an action seeking judicial review of the Secretary of HHS's approval for reimbursement under Section 1122 of its competitor's project to construct a nursing home. The Court held that the petitioner had standing to seek judicial review because: (1) economic injury in the form of increased competition plainly can form the basis of a case or controversy, (2) the injury is traceable to the Secretary's decision, and (3) petitioner's interest is clearly within the zone of interests protected by the law because the petition alleged failure to comply with regulatory procedures for public notice to interested parties such as petitioner.

(B) Competitors denied standing

i. Chalmette General Hospital, Inc. v. Secretary of Health, Education and Welfare No. 78-309 (E.D.La. Mar. 14, 1978)

A competitor hospital sought declaratory and injunctive relief and judicial review of determinations of the Secretary under Section 1122 relating to the approval for reimbursement and extension of time to secure financing for their competitor's project to construct a new hospital. The Court held that mere economic harm in the form of threatened lessened profits in the event the new hospital was constructed did not give the hospital standing to obtain judicial review.

(2) Consumer organizations

(A) Wilmington United Neighborhoods v. United States 615 F.2d 112 (3rd Cir. 1980), cert.den., 449 U.S. 827 (1980)

Consumers of medical services brought an action in federal court challenging a DPA decision making findings recommending approval for reimbursement under Section 1122 of a project to relocate hospital services from the inner city to suburban Wilmington. Plaintiffs also challenged the DHHS determination to reimburse for capital costs associated with the project. The Court held that the plaintiffs had standing to bring the action because: (1) the hospital relocation, which would probably not occur in the absence of Section 1122 approval, could result in the loss to plaintiffs of necessary, accessible, and cost efficient health care, and (2) as consumers plaintiffs were clearly within the zone of interests Section 1122 was designed to protect. However, the Court held that plaintiffs could not obtain federal court review of the DPA and DHHS recommendation and determination. See GUIDE supra.

c. Consolidation, Intervention, Etc., In Judicial Review Proceedings

(1) Chalmette General Hospital, Inc. v. Cherry 398 So.2d 599 (La.Ct.App. 1981), writ den. 400 So.2d 211 (La 1981)

A hospital brought an action seeking a writ of mandamus alternatively to compel the state DPA to hear its administrative appeal of a DPA decision recommending approval, under Section 1122, of a project proposed by its competitor, St. Bernard General Hospital, or for judicial review of the DPA decision. The Court denied relief on the grounds that the plaintiff had failed to join St. Bernard because the action questioning the validity of the certificate of need granted to St. Bernard would so directly affect the rights of St. Bernard and St. Bernard's interests in the subject matter of the action were so interrelated that St. Bernard was an indispensable party without whom the action could not be adjudicated.

(2) National Medical Enterprises, Inc. v. Guissinger 432 So.2d 369 (La.Ct.App. 1983)

A hospital brought an action seeking judicial review of a DPA decision making findings recommending approval, under Section 1122, of its competitor's hospital construction project. The competitor, Lifemark, was not made a party to the action and, although it filed various motions including a motion to dismiss in the Court of Appeals, did not intervene. The Court held that: (1) Lifemark lacked procedural standing to move for dismissal because the crux of NME's petition for judicial review was the question of the propriety of an administrative certificate of approval granted to Lifemark; and this question could not be considered by the courts without Lifemark, whose rights were so directly affected, being joined as a party to the litigation. (citing Chalmette General Hospital, Inc. v. Cherry supra).

2. Judicial Review of Certificate of Need Decisions: Jurisdictional Issues

a. Availability of Relief by Way of Judicial Review of State Agency Decisions

(1) Availability of relief by way of federal court judicial review of state agency decisions

(A) Women's Community Health Center of Beaumont, Inc. v. Texas Health Facilities Commission 685 F.2d 974 (5th Cir. 1982)

An abortion center brought an action in federal court seeking to enjoin state proceedings brought by THFC to bar it from operating without first obtaining a CON. The Center alleged that the state proceedings were discriminatory and exceeded the state's power to regulate abortions in violation of the constitutionally protected privacy interests of abortion recipients.

The Center was established in 1978. In early July 1979 THFC brought a CON enforcement action seeking to halt the Center's operation until it obtained a CON. In late July 1979 the Center filed a CON application and the state ceased active prosecution of the enforcement suit. In August 1980 THFC denied the CON application and requested the state AG to revive the enforcement action. In October of 1980 the Center brought an action in state court seeking judicial review of the CON denial and filed this action, asking the

Court to: (1) find that THFC's decision that the Center was a covered "health care facility" which did not meet the state CON review criteria was unsupported by substantial evidence; and (2) find that, even if THFC's determinations were consistent with the state CON statute, they were inconsistent with NHPRDA and rendered void by application of the Supremacy Clause. The Center sought declaratory and injunctive relief barring the enforcement action or directing THFC to grant it a CON.

The Court dismissed the Center's action, applying the Younger doctrine of federal abstention to avoid interference with ongoing state judicial proceedings necessary for the vindication of important state policies. First, the Court concluded that the state CON enforcement action was an ongoing, unabandoned judicial proceeding because its dormancy during the period when the Center's CON application underwent review and while this lawsuit was pending simply reflected a sound exercise of prosecutorial discretion not to close down a facility that might be approved nor actively litigate an enforcement action which the Center was seeking a federal court injunction to restrain. Second, the Court held that the enforcement proceeding implicated important state interests. It rejected the argument that the state lacked an important interest in enforcing the state CON law because the law was passed merely to implement NHPRDA, basing its ruling on the grounds that: (1) the state's interest in ensuring economical health care for its citizens (a stated purpose of the state CON statute) was no less important than the federal government's interest in health planning, public health regulation being long regarded as one of the state's primary and most important police powers; (2) NHPRDA gives the state a central role in administration of the health care planning program including: (a) recognizing state CON programs to be the basic component in an overall capital expenditure control effort (citing the legislative history of the Health Planning and Resources Development Amendments of 1979); and (b) charging the state alone with CON enforcement; and (3) such an argument is inconsistent with the notion of a healthy, cooperative federalism on which both NHPRDA and Younger doctrine are based. Finally, the Court noted that the Center would have a full opportunity to raise its constitutional challenges in the state proceeding.

(2) Availability of relief by way of state court judicial review of state agency decisions:

(A) Cf. Mercy Medical Center v. Idaho Health Facilities Review Board No. L-35732 (Idaho Dist.Ct., Canyon County, July 28, 1982)

A competitor brought an action seeking to overturn the decision of the Idaho Health Facilities Review Board (the state's CON decision-maker) awarding a CON to its competitor to construct an ambulatory surgicenter. In the course of affirming the Board's decision the Court held that the right to oppose the issuance of a CON by a person operating a competing health care facility is a constitutionally protected property interest.

(B) Roman Catholic Diocese of Albany v. New York State Dept. of Health 490 N.Y.S.2d 636 (App.Div. 1985).

Religious organizations and individual health care consumers brought an action seeking judicial review of a state agency decision granting a CON to a birth control clinic to add abortion services. The Court held that the petitioners had the right to seek judicial review of the state agency's determination under NHPRDA and its companion regulations because: (1) A State's adherence to a CON program is a condition of receiving federal financial assistance under NHPRDA; (2) New York has legislatively opted to participate in the federal program; (3) having opted to participate in and receive the financial benefit of the CON program under NHPRDA, New York is bound by the provisions thereof insofar as they mandate access to an appropriate state court for the purpose of challenging a state agency decision; (4) NHPRDA grants the right to judicial review to "persons adversely affected"; (5) federal regulations in effect at the time of the initiation of this proceeding defined the foregoing phrase to include any person residing within the geographical area to be served under the application, regularly using health care services in the area, or participating in the proceeding before the state agency [42 C.F.R. §123.401, 410(14) (1981) (amended 1985)]; (6) the regulations are controlling over any state restriction on access to the courts by persons having a federal right to review of state agency CON decisions; and (7) each of the petitioners was either a resident of the geographical area affected by the proposed project or participated personally or through a representative in the administrative proceeding. Therefore, each has a federally-created right to seek judicial review and each has statutory standing.

b. Standing to Appeal CON Decisions

(1) Applicants

(A) Bayswater Health Related Facility v. New York Dept. of Health 394 N.Y.S. 2d 314 (App.Div. 1977)

A partnership brought an action seeking judicial review of a state agency recession of the agency's conditional approval of the partnership's application for a CON to establish a health-related facility. The Court held that the partnership had standing to bring the action, ruling that whether or not the partnership could obtain project approval, dependent on the financial health of the individual partners, had no bearing on the partnership's standing.

(B) New Britain General Hospital v. Commission on Hospitals and Health Care No. 233575 (Conn.Super.Ct. Hartford Jud.Dist. Dec. 26, 1979)

A hospital brought an action seeking judicial review of a decision of the commission denying its application for a CON to acquire a CT scanner. The Court held that the hospital had standing to appeal the state agency's decision under a statute granting standing to "any health care facility or institution... aggrieved by any decision of the [state agency]" because the hospital had a specific, personal, and legal interest in the subject matter of the state agency's decision and, to the extent that the denied appropriation would bar its pursuit of an expanded business and health care interest, it had been specially and injuriously affected by the application's outcome.

(C) Hospital of St. Raphael v. Commission on Hospitals and Health Care 438 A.2d 103 (Conn. 1980) 1980)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to acquire a CT scanner. The Court held that the applicant had standing to appeal the state agency decision under a statute granting standing to "any health care facility or institution... aggrieved by any decision of the [state agency]" because the hospital had earmarked funds for the purchase of scanner and had already expended funds and set aside space to accommodate the scanner.

(D) Mt. Sinai Hospital v. Commission on Hospitals and Health Care No. CV-80-02406245 (Conn.Super.Ct. Hartford-New Britain Jud.Dist. Feb. 27, 1981)

A hospital brought an action seeking judicial review of the decision of the Commission denying its application for a CON to acquire a CT scanner. The Court held that the hospital had standing to appeal the Commission's decision under a statute granting standing to "any health care facility or institution...aggrieved by any decision of the Commission" because the hospital had a specific, personal, and legal interest in the subject matter of its application before the commission and this interest was specially and injuriously affected by the denial.

(2) Competitors

(A) Competitors denied standing

ii. World War II Veterans Memorial Hospital v. Commission on Hospitals and Health Care No. 16-67-38 (Conn.Super. Ct. New Haven April 24, 1979)

A competitor sought to appeal the order of the Commission approving its competitor's application for approval of a capital budget to develop plans for replacement or expansion of its existing facilities. Appeal of Commission decisions was granted by statute to "any health care facility or institution...aggrieved by any decision of the commission." The Court held that plaintiff competitor's complaint, which alleged that the decision clouded plaintiff's future existence, threatened its financial stability, and had or would affect its ability to plan and staff for the future, was insufficient to establish aggrievement because it alleged mere conclusions and general fears, not specific factual allegations of injury.

iii. Gateway Hospital Corporation v. Dept. of Health and Rehabilitative Services 420 So.2d 337 (Fla.Dist. Ct.App. 1982)

A hospital brought an action challenging the state agency's denial of its petition for a hearing on the agency's issuance to another hospital of a CON to acquire a parcel of land in an area near both hospitals for one million dollars. The state CON statute granted standing to seek an administrative hearing and judicial review to, among others, a "substantially affected person" (FLA. STAT. ANN. 381.494(7)(e)). The Court held that the petitioner lacked standing as a substantially affected persons because: (1) the approval of the application would not result in the establishment of competing services but merely in the acquisition of land for possible future use of a new hospital; (2) the state CON regulations indicated that land acquisitions were inherently noncompetitive by exempting them from the comparative review batching cycles applicable to applications for similar types of services in the same health service area; and (3) any injury to the petitioner caused by an alleged "million dollar foot-in-the-door" competitive advantage in any future CON proceedings gained by the approved hospital was too speculative and tenuous to convert petitioner into a substantially affected party.

iv. Shelby County Hospital Board v. State Health Planning and Development Agency 443 So.2d 1239 (Ala. Civ. App. 1983)

A SHPDA and a CON recipient (St. Vincent's) brought an action seeking dismissals of SCHB's appeal of certain of St. Vincent's CONs. St. Vincent's and SCHB were competing applicants in a multi-applicant consolidated, comparative review of new hospital construction proposals. (See State Health Planning and Development Agency v. Baptist Medical Center.) During the pendency of the comparative review, St. Vincent's applied for and obtained CONs to construct an urgent care center and an ambulatory surgery center in the area. The State CON statute provided that, "[T]he applicant may appeal the decision [of the SHPDA] to the circuit court of the county in which the applicant...is situated."

The Court held that SCHB lacked standing to appeal St. Vincent's urgent care/ASC CON approvals under the foregoing statutory provision. It apparently concluded that the statute granted a right to appeal to a "competing" applicant, but it held that SCHB was not a competing applicant because it had not applied for the same type facilities as St. Vincent's, *citing Lifemark Corp. v. Guissinger*. Since SCHB was not an "applicant", the St. Vincent's approvals were not appealable rulings adverse to an applicant. The Court did hold that SCHB could seek review by way of a common law writ of certiorari.

v. *St. Joseph's Hill Infirmary, Inc. v. Mandl* 682 S.W.2d 821 (Mo.App. 1984)

A nursing home brought an action seeking judicial review of a SHPDA decision granting a CON to its competitor to construct a nursing home. The state CON statute required the SHPDA to conduct a hearing on an application at the request of any "affected person" (defined as the applicant, the HSA, health care facilities in the area, and the public) and gave the applicant and the HSA the right to seek judicial review. The state constitution guaranteed the right to appeal administrative decisions to persons whose "private rights" protected by law were directly affected. The Court ruled that the nursing home lacked standing for the following reasons: (1) persons may have standing to appeal administrative decisions either because their constitutionally-protected private rights are involved or because the legislature grants them appeal rights. (2) The nursing home lacked standing on the former ground because: (a) there is no right to be free from competition; and (b) although there is no question that CON regulation of medical facilities is premised on maintaining the business in healthy condition by reducing competition and thereby insuring that those providing medical service are strong viable entities able to serve the public more effectively and efficiently at lower cost, the purpose is to protect the public, not the regulated companies. As such, competitors may be the beneficiaries of CON procedures but those procedures do not directly affect their private rights. (3) The nursing home lacked statutory standing because: (a) the statute does not expressly provide for plaintiff's standing; (b) the legislative intent appears to have been to deny competitors' standing, as evinced by the facts that: (i) competitors' standing was granted in early versions and then deleted from the final version of the bill that enacted the state CON law; and (ii) the short time periods for review in the law signified a preference for expeditious final action on applications; and (c) the nature of the CON law and process, in which a major purpose is to reduce or stabilize competition to effect economies of operation, and in which HSA's are involved to represent the public interest, does not inherently require an opportunity for appeal by a competitor. (4) The Court observed that the state CON law was enacted in response to NHPRDA but refused to conclude that the state law automatically encompassed whatever might be included in NHPRDA regulations (including 42 C.F.R. §§123.401, 410(a)(14) (1983), which grant competitors standing to appeal CON decisions) because: (a) the state law does not clearly support such a interpretation; and (b) the federal regulations are not mandatory upon the states as they are subject to waiver by the Secretary or subsequent amendment.

(B) Competitors granted standing

i. *Cf. Memorial Hospital of Southern California v. State Health Planning Council* 28 Cal.App. 3d 167, 104 Cal. Rptr. 492 (1972)

Several competitor hospitals brought an action to compel the SHPC (the final decision-maker on CON applications) to hear an appeal from a favorable decision by an area health planning agency concerning their competitor's application to convert its facilities from convalescent to acute care. The appeal had been brought by one-third of the members of the governing body of the area health planning agency, as they were entitled to do by statute, but upon withdrawal of several of the governing body members from the appeal the SHPC had dismissed it. The Court held that the competitor hospitals had standing to bring this action (under the statutory standard for standing to compel non-discretionary official actions) as persons "beneficially interested" because the CON statute allowed them to appear and participate in the lower administrative hearings on the CON application and because they did actually appear and participate.

ii. *Cf. Twin Ports Convalescent, Inc. v. Minnesota State Board of Health* 257 N.W.2d 343 (Minn. 1977)

Existing ambulance services in Duluth brought an action seeking judicial review of a Board decision granting a license to a competitor, Med-A-Van, to operate an ambulance service in the city. State law required a "newly established ambulance service in the state" to demonstrate to the Board's satisfaction at a public hearing that the public convenience and necessity required the proposed service. Following Board denial of their application to establish an ambulance service in Duluth, Med-A-Van's owners had acquired Med-A-Van (a licensed ambulance service operating in Minneapolis) and obtained Board permission without a hearing or determination of public convenience and necessity to open a "branch office" in Duluth. The Court first held that plaintiffs had standing as competitors to bring the action because: (1) they showed an injury in fact by their allegations of diminished profits since defendants commenced operations in the city; and (2) their interest in maintaining the profitability of their business was arguably within those interests sought to be protected by the statutory requirement of a showing of public convenience and necessity since the statute, in recognition of the inelastic demand and fixed costs characteristic of the ambulance service business, was intended to preserve the quality of the service offered to the public by protecting existing services from competition in the absence of a showing that an additional service was in fact needed. Second, the Court held that the state Board erred in granting Med-A-Van a license to operate in Duluth without a public hearing and determination of public convenience and necessity because, given the legislative intention to protect the public welfare against deleterious competition in the ambulance services field, it did not make sense that only a first time licensee was required to demonstrate public convenience and necessity at a public hearing.

iii. Home Health Agency Assembly of New Jersey, Inc. v. Homemakers International Co. No. A-3667-76 (N.J.Super. Ct.App.Div. June 23, 1978)

An organization of the certified and/or licensed home health agencies in a state and several individual non-profit home health agencies brought an action appealing the decision of the Commissioner of Health granting a CON to Homemakers International to provide home health services in areas presently served by the individual agencies. The Court held that all the plaintiffs had the requisite standing to challenge the Commissioner's decision.

iv. Suburban Medical Center v. Olathe Community Hospital 597 P.2d 654 (Kan. 1979)

A hospital brought an action appealing the granting of a CON by the SHCC (the final CON decision-maker in the state) to expand a competitor's facility. The state agency had denied the application. Following a hearing requested by the applicant (and at which the hospital was a party) the SHCC overruled the state agency and granted the CON. The state CON statute permitted the applicant, the state, the HSA, and "the adversely affected health facility" to be parties to the SHCC review proceeding and permitted parties to the SHCC proceeding to seek judicial review. The applicant argued that the hospital lacked standing to seek judicial review for the following reason: Since the hospital had been, in essence, the winner under the state agency decision it had not been an "adversely affected health facility" after the state agency decision and therefore it could not have been a proper party to the SHCC review - the prerequisite to standing to seek judicial review. The Court disagreed and held that the hospital had in fact been an adversely affected facility and therefore did have standing because, as a subsequent amendment to the statute had made explicit, the term "adversely affected" facility covered facilities which could be potentially adversely affected by the final decision on the application.

v. Tulsa Area Hospital Council v. Oklahoma Health Planning Commission No. C-78-972 (Okla.Dist.Ct.Tulsa County Dec. 1, 1978), rev'd on other grounds, 626 P.2d 316 (Okla. 1981)

An organization of local hospitals brought an action appealing the decision of the SHPDA granting a CON to Oral Roberts University (ORU) to construct a new hospital in the area. The trial court indicated that the Council had standing due to the impact which would result to its hospital members if the new hospital were to be constructed.

vi. Hale v. Petit No. CV81-2 (Me.Super.Ct. Kennebec County Feb. 28, 1981), aff'd on other grounds, 438 A.2d 226 (Me. 1981)

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the granting of the other. The Court held that the plaintiff had standing to bring the appeal under the provision of the state CON statute granting standing to seek judicial review to "any person aggrieved." The Court interpreted the phrase "person aggrieved" in the state statute to include competitors, citing similar terminology in the federal health planning regulations which the federal regulations defined to include competitors. (See 42 CFR 123.407(a)(7)(i) (1979)).

(vii) Manor Healthcare Corp. v. Northwest Community Hospital 472 N.E.2d 492 (Ill. App. 1984)

A competitor brought an action seeking judicial review of a state agency decision granting a CON to its competitor to construct a 200-bed nursing home. The Court upheld the state agency decision. It held among other things that the competitor had standing to seek judicial review of the state agency decision because: (1) the state CON statute had been amended in 1982 to grant standing to persons "adversely affected" as part of a general legislative effort to bring the law into compliance with NHPRDA and its regulations; and (2) although state law did not define "adversely affected", NHPRDA regulations defined "persons adversely affected" to include health care facilities such as the plaintiff competitor located in the area and providing similar services to those under review. (42 C.F.R. §123.410(a)(14) incorporating by reference 42 C.F.R. §123.401 (1984)).

(viii) Bradbury Memorial Nursing Home v. Tall Pines Manor Associates 485 A.2d 634 (Me. 1984)

A nursing home (Bradbury) brought an action seeking judicial review of the issuance of a CON to its competitor (TP) for new nursing home construction. TP, BMA (an association proposing to purchase Bradbury), and a third competitor (Northpoint) filed competing CON applications within the October 15, 1982 review cycle proposing to construct new nursing home facilities to satisfy a state-identified need. The HSA recommended approval of the BMA application, but BMA withdrew its application March 4, 1983. On April 4, 1983, after the review cycle expiration date, the state agency approved the TP application and denied Northpoint's application. Bradbury unsuccessfully sought an administrative reconsideration and then brought this action.

The Court upheld the state agency decision, holding among other things that Bradbury had standing to maintain the action because: (1) Bradbury met the statutory standing requirement that it be a "person aggrieved by a final decision" of the state agency; and (2) Bradbury also demonstrated that the state's action caused it a particularized injury since: (a) the express legislative intent of the state CON statute to regulate distribution of health care facilities to avoid unnecessary duplication reflected a legislative purpose to regulate competitive interests; (b) an injured competitor therefore has standing to require compliance with the law; and (c) as an existing nursing home in the same city as TP's proposed facility, Bradbury was a directly and particularly injured competitor. The Court observed that Bradbury's standing extended to all issues regardless of whether they specifically related to its injury, and the fact that Bradbury's success might simply lead to the issuance of a CON to Northpoint or another applicant did not defeat its standing.

(3) Health Systems Agencies

(A) Georgia-Tennessee Regional Health Commission v. Tennessee Health Facilities Commission and Diagnostic Center Hospital No. 80-116-II (Tenn.Ct.App. Jan. 6, 1981)

An HSA brought an action seeking judicial review of a state agency decision granting a CON to expand a hospital. The state Administrative Procedure Act provided for judicial review of final administrative decisions at the instance of an "aggrieved person." The Court held that the HSA was not an "aggrieved person" and did not have standing because:

(1) the HSA's role in CON review, as indicated by the state CON statute and NHPRDA, is that of a subordinate official recommendatory agency and such a subordinate agency should not be granted standing to force its recommendations upon an unwilling superior regulatory commission (citing Minnesota State Board of Health v. Governor's Certificate of Need Appeal Board); (2) the fact that the Commission's regulations authorized HSAs to appeal SHPDA decisions to the Commission did not authorize the HSA to appeal the Commission's decisions to the courts. Compare Memorial Hospital of Southern California v. State Health Planning Council supra; (3) The fact that NHPRDA contained provisions requiring a complying state CON program to permit HSAs to obtain judicial review of final CON decisions (Section 1532(b)(12)(E), 42 U.S.C.A. 300n-1(b)(12)(E)) did not require granting standing to the HSA because: (a) the federal law does not appear to be self-executing, (b) the state agency had not in fact adopted procedures granting HSA's standing to seek judicial review, and (c) even if it had it is extremely doubtful that an administrative agency has the authority to create a legal right of standing in the courts.

(B) Kentucky Health Systems Agency - West, Inc. v. Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board No. 80-CI-2140 (Kentucky Circuit Court Franklin County January 23, 1981)

An HSA brought an action seeking judicial review of a state agency decision approving an application for a CON to establish an open-heart surgery unit. The state CON statute expressly conferred standing on the HSA throughout the administrative review process but was silent with respect to HSA standing to seek judicial review. The Court held that the HSA lacked standing to seek judicial review because the express conferring of standing on the HSA in the administrative process implied a legislative intent not to grant standing to seek judicial review.

(C) East Tennessee Health Improvement Council, Inc. v. Tennessee Health Facilities Commission 626 S.W.2d 272 (Tenn.Ct.App. 1981)

An HSA brought an action seeking judicial review of a state agency decision granting a CON, over the HSA's recommendation to deny, to an existing hospital to add beds. The state Uniform Administrative Procedures Act (APA) governing the action granted standing to seek review to any "person aggrieved." Following and quoting at length from its earlier, unreported decisions on HSA standing to appeal, the Court held that the HSA lacked standing. [See Georgia-Tennessee Health Facilities Commission and Diagnostic Hospital supra.] In addition to following its own precedants, the Court declined to apply the reasoning of

Memorial Hospital of Southern California which held that competitors had standing as persons "beneficially interested" to bring a suit seeking to compel administrative action on a CON application because the CON statute allowed them to appear and participate in lower administrative proceedings and they did actually appear and participate.

(4) State agencies

(A) Minnesota State Board of Health v. Governor's Certificate of Need Appeal Board 230 N.W. 2d 176 (Minn. 1976)

Four nursing homes brought an action appealing the decision of a trial court which reversed the favorable decisions of the Governor's Certificate of Need Appeal Board (CONAB) on their CON applications and reinstated the decisions of the state Board of Health denying their applications for CONs to expand their facilities. Under the state CON statute and the state APA, CON applications are first reviewed at the state level by the Board of Health. Persons aggrieved by a Board of Health decision may appeal to the CONAB. Persons aggrieved by the CONAB decision may appeal to the courts. In this case the Board of Health appealed the CONAB decisions to the trial court. The state Supreme Court held that the Board of Health had lacked standing as a person aggrieved to take the appeal to the trial court because the decision of the Board of Health was an intermediate step in an administrative adjudicatory (quasi-judicial) process culminating in a final decision by the CONAB and an inferior administrative adjudicatory agency cannot have an interest in appealing, nor would it be appropriate to permit it to appeal, the decision of administrative authority above it. Consequently, the Supreme Court reversed the trial court decision.

(5) Consumers, area residents, taxpayers, etc.

(A) Blue Cross v. Kenley No. 77C631 (Va.Cir.Ct. Henrico County October 14, 1977)

Blue Cross (apparently the State Blue Cross Association) brought an action seeking judicial review of a state agency decision awarding an applicant a CON to construct a new hospital. The Court held that Blue Cross lacked standing to bring the action because: (1) Blue Cross was not among the classes of persons expressly granted standing to seek judicial review of CON decisions in the CON statute and (2) Blue Cross was not a "person aggrieved" within the meaning of the phrase in the provision of the state APA granting standing to such persons because the granting of the CON was not directed to Blue Cross nor did it directly affect any pecuniary or property right of Blue Cross. Blue Cross alleged that if the hospital construction project were allowed to proceed the cost of services would increase and such cost increases would be borne largely by Blue Cross and its subscribers, but the Court concluded that Blue Cross would be affected only indirectly through its contracts with the hospital and its subscribers. The Court indicated that it was difficult to see how Blue Cross could be "aggrieved" if it had not been ordered to do anything, the order had not been addressed to it, and there was no effort to exercise any authority over it.

(B) Northbrook Residents Association v. Iowa Dept. of Health, Office for Health Planning and Development 298 N.W. 2d 330 (Iowa 1980)

A resident's association brought an action seeking judicial review of the decision of the state agency granting a CON to construct a residential care facility for mentally retarded adults in its community. The association had participated in the agency proceedings and hearings on the application. The respondents argued that the association lacked standing to seek judicial review under the state CON statute and the state APA. The Court (1) reversed a trial court ruling that the respondents had waived this objection by permitting the association's earlier participation, holding that standing is jurisdictional and therefore can be raised at any time, and (2) dismissed the lawsuit, ruling that the association had failed to present any evidentiary showing of entitlement to standing.

(C) Shoolman v. Health Facilities Appeals Board 413 N.E.2d 742 (Mass.App. 1980)

A ten-taxpayer group brought an action seeking judicial review of a state agency decision granting a CON to a hospital to construct an ambulatory care center. The state statute authorized ten-taxpayer groups to seek administrative appeals of state agency decisions and bring enforcement actions in the Courts but did not specifically authorize them to seek judicial review. The Court held that ten taxpayer groups had standing to seek judicial review because: (1) to interpret the statutory scheme otherwise would severely qualify the provision authorizing enforcement actions, and (2) the Court was reluctant to interpret narrowly the rights of review of taxpayers under a statute which made the interest and role of the public of central importance.

(D) Roskey v. Texas Health Facilities Commission 630 S.W.2d 844 (Tex.Civ.App. 1982)

A taxpayer's association brought an action seeking a declaratory judgement that a CON exemption certificate issued to a district hospital was invalid. The application for the exemption certificate was filed on April 25, 1979 and approved on July 26, 1979. Between those dates, on May

17, 1979, a statutory amendment became effective repealing the sole ground on which the exemption certificate was issued.

The Court held that the plaintiffs lacked standing to bring the action. The taxpayers alleged that the district intended to levy new taxes to pay for the project authorized by the exemption certificate. Because the district had not yet taken any steps to levy such taxes and because it had the authority to finance the project through other than tax revenues, the Court ruled that the plaintiff's alleged injury was founded on a contingency, insufficient to support standing. The Court concluded that at this point the exclusive right to contest the validity of the exemption certificate lay with the state through an action in quo warranto against the hospital district.

(E) Roman Catholic Diocese of Albany v. New York State Dept. of Health 490 N.Y.S.2d 636 (App.Div. 1985)

Religious organizations and individual health care consumers brought an action seeking judicial review of a state agency decision granting a CON to a birth control clinic to add abortion services. The petitioners had participated in a state agency hearing on the application.

The Court held among other things that the petitioners had the right to seek judicial review of the state agency's determination under NHPRDA and its companion regulations because: (1) A State's adherence to a CON program is a condition of receiving federal financial assistance under NHPRDA; (2) New York has legislatively opted to participate in the federal program; (3) having opted to participate in and receive the financial benefit of the CON program under NHPRDA, New York is bound by the provisions thereof insofar as they mandate access to an appropriate state court for the purpose of challenging a state agency decision; (4) NHPRDA grants the right to judicial review to "persons adversely affected"; (5) federal regulations in effect at the time of the initiation of this proceeding defined the foregoing phrase to include any person residing within the geographical area to be served under the application, regularly using health care services in the area, or participating in the proceeding before the state agency [42 C.F.R. §123.401, 410(14) (1981) (amended 1985)]; (6) the regulations are controlling over any state restriction on access to the courts by persons having a federal right to review of state agency CON decisions; and (7) each of the petitioners was either a resident of the geographical area affected by the proposed project or participated personally or through a representative in the administrative proceeding. Therefore, each has a federally-created right to seek judicial review and each has statutory standing. The Court rejected the state agency's argument that petitioners' NHPRDA right to judicial review was eliminated by federal CON regulation amendments adopted January 14, 1985 during the pendency of these proceedings which deleted the regulatory definition of "affected persons." It held that the regulatory amendment should not be applied to undo standing already validly acquired because there was nothing to indicate that the deletion was intended to restrict standing to obtain judicial review of CON decisions or that it was designed to apply retroactively to already pending judicial review proceedings in which a party had valid standing when the proceeding was commenced. The Court also rejected the state agency's contention that Congress lacked the constitutional right to enlarge the jurisdiction of New York courts by conferring standing where it would not exist under state law, holding that once a justiciable controversy exists, as here, standing is a question within the constitutional power of Congress to statutorily determine.

c. Consolidation, Intervention, Etc., In Judicial Review Proceedings

(1) See cases annotated at Section III.A.8. "Consolidation, Intervention, Etc., in Administrative Review Proceedings" and cases annotated at Section III.A.19.a.(3) "Consolidation, intervention, etc., in administrative appeals."

(2) Naples Community Hospital, Inc. v. Dept. of Health and Rehabilitative Services 463 So.2d 375 (Fla.Dist.Ct.App. 1985)

A hospital brought an action seeking leave to intervene in an action brought by a new hospital construction project proponent (Collier) to compel the state agency to issue it a CON. Collier's action alleged that its pending CON application was "deemed approved" by default due to state agency delay in granting or denying the application. The plaintiff (which was located in Collier's proposed service district) Naples had filed a CON application, also still pending, for a satellite facility in the district at the same time as Collier. The Court granted Naples leave to intervene, holding that: (1) the test for intervention in such a case is whether the plaintiff has an interest in the matter in litigation of such a direct and immediate character that it will gain or lose directly by the judgment; (2) Naples had an interest in the matter in litigation because it was an existing hospital and a CON applicant in the service district targeted by Collier; and (3) Naples' interest had the required direct and immediate character by reason of its CON application in the fixed pool of needed hospital beds in the pertinent service area, since if Collier received a CON by default, it could have the effect of directly barring approval of Naples' application.

(3) State Health Planning and Development Agency of Alabama v. Baptist Medical Center 446 So.2d 419 (Ala. Civ. App. 1983)

A SHPDA brought an action seeking to interplead in one judicial proceeding all of the disapproved applicants who had participated in an administratively consolidated, comparative review of their new hospital construction proposals. Six hospitals had applied, been denied CONs, and separately appealed their denials to several circuit courts. The State CON statute provided that, "[T]he applicant may appeal the decision [of the SHPDA] to the circuit court of the county in which the applicant...is situated." The Court ordered the six appeals consolidated in the circuit court for the county in which the SHPDA was located, holding that: (1) the statutory provision for judicial review was inapplicable because from the use of the word "applicant" it appeared evident that the legislature could not have intended to intentionally create a scenario which would permit the possibility of conflicting judgments of circuit courts on appeal from one agency decision; and (2) in the exercise of the Court's general superintendance and control over matters such as this in which it had exclusive appellate jurisdiction, the Court could issue the necessary remedial orders and writs to prevent judicial disorder, including ordering consolidation of the appeals in the circuit court where venue would lie under the general venue statute for appeals from state agency rulings.

d. Issues Cognizable On Review

(1) Tulsa Area Hospital Council v. Oklahoma Health Planning Commission No. C-78-972 (Okla.Dist.Ct. Tulsa County Dec. 1, 1978), rev'd on other grounds 626 P.2d 316 (Okla. 1981)

An organization of local hospitals brought an action appealing the decision of the SHPDA granting a CON to Oral Roberts University (ORU) to construct a new hospital in the area. ORU contended that whether the Council had standing depended on whether the interest it sought to protect was a recognizable, redressable legal right under state law. It argued that the Council had no such right in this case because: (1) the state APA authorized the court to grant the Council relief only if its "substantial rights" had been "prejudiced," and (2) the Council had no substantial right to be free from competition. The Court rejected this argument by reasoning that: (1) standing and existence of a legal interest are distinct issues, (2) economic injury sufficed to give standing, (3) once the Council had standing it became entitled to argue and seek relief on behalf of the public interest, and (4) the public had a sufficient legal interest in assuring that the agency acted properly.

(2) Bradbury Memorial Nursing Home v. Tall Pines Manor Associates 485 A.2d 634 (Me. 1984)

A nursing home (Bradbury) brought an action seeking judicial review of the issuance of a CON to its competitor (TP) for new nursing home construction. TP, BMA (an association proposing to purchase Bradbury), and a third competitor (Northpoint) filed competing CON applications within the October 15, 1982 review cycle proposing to construct new nursing home facilities to satisfy a state-identified need. The HSA recommended approval of the BMA application, but BMA withdrew its application March 4, 1983. On April 4, 1983, after the review cycle expiration date, the state agency approved the TP application and denied Northpoint's application. Bradbury unsuccessfully sought an administrative reconsideration and then brought this action. In the course of upholding the state agency decision and ruling that Bradbury had standing to bring this action, the Court observed that Bradbury's standing extended to all issues regardless of whether they specifically related to its injury, and the fact that Bradbury's success might simply lead to the issuance of a CON to Northpoint or another applicant did not defeat its standing.

3. Actions to Enforce CON Laws Against Health Facilities, Etc.: Availability of Relief and Standing Issues

a. HSAs

(1) Finger Lakes Health Systems Agency v. St. Joseph's Hospital 412 N.Y.S. 2d 419 (App.Div. 1981)

An HSA brought an action to enjoin a hospital, a professional corporation of radiologists, and others from constructing a building and acquiring and installing a CT scanner in the building without first obtaining a certificate of need. The Court dismissed the HSA's action on the grounds that the agency was not entitled to bring an action to enforce the CON statute because: (1) by law the HSA's function is primarily advisory, the Attorney General having statutory CON enforcement authority, and (2) the HSA's performance of its functions was not adversely affected by the defendants' actions nor was the HSA within the zone of interests protected by the CON statute.

(2) South Central Health Planning and Development, Inc. v. Commissioner of Department of Administration 628 P.2d 551 (Alaska 1981)

An HSA brought an action to enjoin construction of a skilled nursing unit within a home for the aged on the grounds that the facility had failed to submit the project to CON review. The Court held that the HSA had standing to bring the action under a provision of the state CON statute granting the right to enjoin violations to "member[s] of the public substantially and adversely affected" because: (1) the HSA qualified as a member of the public because a majority of its governing body must be consumers, residents of the health service area, and broadly representative of the public; (2) the construction of a health care facility in its area which did not conform to its plan would substantially and adversely affect the agency by disrupting the plan, undercutting the agency's statutorily delegated planning activities, and subverting the purposes of health systems planning; and (3) the agency is defined in state CON regulations as a "person directly affected" by the approval or denial of a CON.

b. Consumers, Area Residents, Taxpayers, Insurers, Etc.

(1) Monmouth-Ocean Coalition for Life v. Women's Medical Center of Howell, Inc. No. A-2616-80T3 (N.J.Super.App. Div. June 22, 1981)

A citizens' organization brought an action to enjoin an abortion clinic from operating without first obtaining a certificate of need. An administrative hearing to determine whether the clinic was subject to the CON statute was pending and the state agency had permitted the clinic to operate while that proceeding was pending. The Court held that the organization was not entitled to bring the action because: (1) the state CON statute vested authority to do so in the Department of Health, and (2) the state CON statute cannot be interpreted to impliedly create a private cause of action on behalf of the plaintiff because: (a) the statute was not adopted to benefit the class of persons of which plaintiff is a member, (b) the statute indicates a legislative intent to deny a private remedy by expressly authorizing public enforcement, and (c) a private remedy would be inconsistent with the underlying regulatory scheme since it would interfere with the state agency's administrative review and determination of whether the clinic was covered by CON.

c. Competitors

(1) Georgia Baptist Medical Center v. Metro Ambulance Services, Inc. 296 S.E.2d 547 (Ga. 1982)

A helicopter ambulance service brought an action seeking to enjoin a hospital from operating its own helicopter ambulance service without first obtaining a CON. The state CON statute granted the SHPDA "in addition to any other proper parties" standing to maintain an enforcement action (GA. CODE ANN. §88-3320(c)). The Court held that the statute did not give standing to a competitor of a health service provider to enforce the CON law because: (1) the accomplishment of the purpose of the CON statute (implementing health facility regulatory policy through an administrative agency) is best established through the agency and an attempt to achieve the goals of the law through random litigation would likely result in more confusion rather than the orderliness mandated by the statute; and (2) the Court could not construe the statute as a mechanism for determination of the respective rights of competitors. The Court noted that its ruling did not deprive the public of the right to bring an action in mandamus to compel the SHPDA to enforce the law.

d. State Agency

(1) Cf. People v. City of Colorado Springs No. 82 CA0463 (Colo. Ct. App. Dec. 16, 1982) aff'g. No. 81 CV2863 (Colo. Dist. Ct., El Paso Cty. Feb. 17, 1982

A state agency brought an action seeking to enjoin a hospital from adding a new open heart surgery service without first obtaining a CON and seeking judicial enforcement of a declaratory order of the state CON appeals board, the Health Facilities Review Council (HFRC), that the hospital project was subject to CON review. The trial court denied both forms of relief sought, reaching the merits of whether the hospital was entitled to a CON only in its decision on injunctive relief. The state appealed only the denial of its motion for enforcement of the HFRC declaratory order, not the decision denying an injunction.

The state CON statute in effect at the time provided an opportunity for a "potential applicant" to obtain a declaratory ruling on whether a proposed project required a CON (§25-3-506(5), C.R.S. 1973 (1981 Cum.Supp.)). However, State agency regulations purported to authorize "any person" including HFRC staff to petition for a ruling.

The Court held that the state agency did not have the authority to petition for a declaratory ruling under Section 25-3-506(5) because: (1) In 1982 the legislature repealed and re-enacted the section with an express provision authorizing HFRC staff to petition for a ruling. If the legislature had intended this power to be implicit in the earlier law it would not have been necessary to adopt the amendment; and (2) the state agency was not without alternate remedies of requesting an injunction or filing criminal proceedings if the law was violated.

4. Other NHPRDA and State CON-Related Availability of Relief and Standing Cases

a. NHPRDA-Related Cases

(1) Cf. New York City Coalition for Community Health v. Lindsay 362 F.Supp. 434 (S.D.N.Y. 1973)

Several community groups, a coalition of organizations that had formerly been experimental district boards advising a 314(b) CHP agency, and various individuals brought actions seeking declaratory and injunctive relief against the local CHP 314(b) agency alleging violations of the Public Health Service Act applicable to 314(b) agencies and violations of the agency's federal grant application, especially with regard to the establishment and composition of the agency's governing board and district boards. The Court held that the community organizations and the coalition had standing to bring the action because they had demonstrated an interest in community health planning through expenditure of time and money thereon and thus were within the zone of interests protected by the Comprehensive Health Planning and Public Health Services Amendments of 1966 (P.L. 89-749), which created an areawide structure for strengthing local participation in the planning for health services. The individual plaintiffs lacked standing, however, because they did not allege that they were directly involved in local health planning.

(2) *Cf.* *Clinton Community Hospital v. Southern Maryland Medical Center* 510 F.2d 1037 (Fourth Cir. 1975), *affg*, 374 F.Supp. 450 (D.Md. 1974)

A hospital brought an action alleging, among other things, violation of provisions of various federal environmental laws and P.L. 89-749, (the Comprehensive Health Planning and Public Health Services Amendments of 1966 ([42 U.S.C.A. §246]) by several state agencies in the course of approving under the state CON and licensure laws a competitor's project to construct a new hospital. The Court of Appeals held that the hospital: (1) had no standing to sue because its economic well-being vis-a-vis its' competitors is not arguably within the zone of interests protected by the federal environmental laws, and (2) failed to state a claim upon which relief can be granted because it sought injunctive relief because of the impact of *existing* environment on the *proposed* hospital, turning the federal environmental laws 180 degrees around. The Court also affirmed the District Court ruling that the hospital failed to state a federal claim because even if the state had violated the federal act the gravamen of the plaintiff's complaint alleged a violation of provisions of the state CON law *not* mandated by federal law.

(3) *Aldamuy v. Pirro* 436 F.Supp. 1005 (N.D.N.Y. 1977)

Minority community consumer representatives brought an action against an HSA and the Secretary of HEW challenging the composition and selection of the HSA's governing body and the Secretary's approval of the governing body. The plaintiffs had participated in the HSA's governing body nomination process and two of them had sought membership on the governing body. The Court held that the plaintiffs had alleged sufficient demonstrable, particularized injury to establish their standing to bring the action.

(4) Greater St. Louis Health Systems Agency v. Teasdale 506 F.Supp. 23 (E.D.Mo. 1980)

An HSA and individual HSA members brought an action seeking declaratory and injunctive relief and alleging that various provisions of its state's certificate of need statute were inconsistent with NHPRDA and implementing regulations and therefore void under the Supremacy Clause. They raised this assertion as to provisions of the state CON statute which: (1) defined "health systems agencies" for state law purposes in such a way that some federally-designated health systems agencies would lose their right, granted under state law as required by NHPRDA regulations, to an administrative appeal of a state CON decision inconsistent with their recommendation and to a copy of the final state agency decision. [See 42 C.F.R. §123.407(a)(9), (10) (1979).]; (2) required selection of HSA governing body members by local government officials; (3) provided that it be a misdemeanor for HSA members or employees to use any state, federal, or local funds for lobbying activities with the state legislature; and (4) provided for a state-level CON program inconsistent with NHPRDA in several ways.

The Court held that the HSA only had standing to assert its 1st, 2nd, and 3rd claims because only those claims related to sections of the state CON statute which affected the HSA.

(5) Hicks, et al. v. Southern Maryland Health Systems Agency No. R-80-2980 (U.S.D.C., D.Md. March 8, 1983)

Ex-employees of an HSA brought an action against the HSA and its Executive Director and the federal, state, and local governments alleging wrongful or discriminatory discharge in violation of rights protected under the First, Fifth, and Fourteenth Amendments; Title VI and VII of the Civil Rights Act; the federal Health Planning Act (NHPRDA); and various other federal and state laws. The HSA was a "public regional planning body-type" HSA (See 42 C.F.R. §122.102(b)) established by four counties pursuant to a state statutory authorization. It had a governing board comprised of local government officials and a separate governing body, selected in accordance with NHPRDA and federal regulations, with exclusive responsibility for the agency's health planning functions (See 42 C.F.R. §122.109(d)). The plaintiffs were dismissed, in part for breach of an internal policy and for allegedly making false statements adversely affecting the agency's reputation. The Court held, among other things, that the plaintiffs lacked standing to raise the claim that their termination violated NHPRDA on the grounds that the composition of the governing body was provider-dominated (and opposed to their consumer orientation) or that it was insufficiently representative of the minority groups of which they were members. [*Compare Aldumuy v. Pirro*.] Assuming *arguendo* that a cause of action on behalf of plaintiffs could be implied under NHPRDA, plaintiffs lacked standing because although they sufficiently alleged injury in fact, they failed to show (assuming a causal relationship between the governing body composition and their discharge) that the governing body composition requirements were enacted to prevent discrimination in employment. The Court concluded that the statutory composition requirement was enacted to forestall a bias in favor of health care providers resulting, for example, in the compiling of a health systems plan not adequately serving the needs of area consumers.

(6) *Wisconsin Hospital Association v. State Dept. of Health et al.* No. 82-CV-2653 (Wisc.Cir.Ct., Dane Cty., Mar. 8, 1983)

A hospital association brought an action seeking a declaratory judgement that the state's statutory CON moratorium conflicted with NHPRDA and thus was unconstitutional under the Supremacy Clause; and that the informal procedures used by the SHPDA to administer the moratorium were invalid because not formally promulgated as regulations. The Court held that WHA had standing to bring the action because it was an organization some of whose members would have standing to bring the action in their own names, since they had been or would be directly affected by being prevented by the moratorium from using their property to provide services needed by the public.

b. CON-Related Cases

(1) *Cf. Mid-Atlantic Nephrology Center Ltd. v. Califano* 433 F.Supp. 23 (D.Md. 1977)

A renal dialysis clinic and a state Comprehensive Health Planning Agency (314(a) agency) brought an action to enjoin HEW from reimbursing a competitor dialysis clinic under the ESRD program. They claimed that HEW violated its own regulations in approving the competitor clinic for ESRD reimbursement. The Court held that both plaintiffs had standing to bring the action - the clinic satisfactorily alleging present and prospective economic harm to its present and proposed facilities and the CHP agency alleging damage to the integrity of its comprehensive health plan and unnecessary increases in the cost of the state's dialysis reimbursement program. These allegedly injured interests were within the zone of interests regulated by the ESRD statute and regulations. The Court also permitted plaintiffs to press other claims which were based on alleged violations of provisions of the regulations designed to protect the public interest and not any particular interest of either plaintiff.

(2) Pratt v. Board of County Commissioners 597 P.2d 664 (Kan. 1979)

A taxpayer group brought an action against their local government to enjoin the issuance of general obligation bonds for the construction of a new hospital. The bond issue was by law conditioned on possession of a CON for the project; as a consequence the validity of a CON previously awarded for the project was at issue. Defendants claimed that plaintiffs were not entitled to bring this action which they characterized as a collateral attack on the CON. The Court held that plaintiffs were entitled to bring the action because, although they lacked the right to appeal the issuance of the CON (that right being granted by statute only to the applicant, the HSA, and competitor facilities), the bonding authority statute provided that persons whose taxes or property would be affected by the bond issuance were entitled to bring an action to enjoin the issuance.

(3) Blanchester Care Center, Inc. v. Ackerman No. 81AP-113 (Ohio Ct.App. Franklin Cty. Nov. 5, 1981)

BCC nursing home brought an action seeking a writ of mandamus to compel the state agency to require a competitor, Blanchester Area Care (BAC), to obtain a certificate of need. Prior to June 8, 1979 BAC had obtained approval for its project under the state's 1122 program. In early 1979 the state passed a CON law. Transition provisions in the regulations implementing the statute exempted projects which had received 1122 approval before June 8, 1979 and whose proponents supplied "proof of obligation" for the project. Proof of obligation was defined to required a written enforceable construction contract providing for construction to begin within 90 days of its execution on an already acquired site and to proceed without interruption to completion unless halted by reasons beyond the control of the holder of the CON. (O.A.C. §3701-80-5, 8-01(W)(1979)). Proof of obligation was required to be submitted within one year, with an opportunity for a one-year extension for good cause. BAC obtained a binding option to purchase the land for its proposed facility, conditioned upon rezoning. In part because of delay in obtaining rezoning (including delay caused by an ultimately invalidated petition for a public referendum on the rezoning requested by associates of the BCC) BAC did not enter into a construction contract until May, 1980. In June 1980 the state agency informed BAC that by virtue of its contract it was exempt from CON review provided continuous, uninterrupted construction began within 90 days. Site preparation and bulldozing a portion of the construction site began in late August 1980, but stopped shortly thereafter because of the onset of winter, and the

February 1981 filing of this action. In addition, BAC did not acquire title to the property until December 1980, after construction work had begun. BCC argued that BAC was not entitled to an exemption because it did not have an already acquired site when it entered into the construction contract and because uninterrupted construction did not occur within 90 days of the contract's execution.

The State mandamus statute permitted the writ to issue on the application of a person beneficially interested in the act sought to be compelled. The Court held that BCC had standing to bring the action because: (1) as a general rule competitors lack standing unless they can claim the benefit of an implied or expressed statutory aid to standing, but BCC could make such a claim since: (a) the state CON statute granted competitors the right to participate in the administrative proceedings on a CON application and seek judicial review; and (b) although the CON statute did not directly apply to actions in mandamus it indicated a legislative conclusion that the public interest in adequate healthcare services would be furthered by some restriction on competition; and (2) NHPRDA (in response to which the state CON statute had been enacted) was intended to achieve a number of public interest goals and BCC, as a local citizen, was asserting the public interest in the proper administration of the regulatory scheme.

(4) In re Wilkesboro, Limited 285 S.E.2d 626 (N.C.Ct.App. 1982), cert.den. 290 S.E.2d 365 (N.C. 1982)

A skilled nursing facility brought an action seeking judicial review of a state agency denial of its request for a hearing to reconsider the state agency's decision that the SNF construction project of its competitor (Wilkesboro), located in the same county and less than two miles from petitioner, was exempt from CON under a statutory grandfatheir clause. The state agency's decision consisted of a letter informing Wilkesboro that it could continue construction without meeting the requirements of the CON law.

The state agency had denied the petitioner's request on the grounds that under the state's CON regulations a reconsideration hearing was available only to "persons aggrieved", and petitioner was not within that category. The state CON statute required that the state agency comply with the state APA and give persons qualifying as "persons aggrieved" under the APA the administrative appeal and judicial review rights provided under that Act. The state APA provided that "Any person who is aggrieved by a final agency decision in a contested case, and who has exhausted all administrative remedies made available to him by statute or agency rule, is entitled to judicial review...." The state APA also defined persons aggrieved as persons "directly or indirectly affected substantially in their person, property, or public office or employment by an agency decision" and the CON regulations defined "persons aggrieved" in identical terms. Finally, the APA defined a "contested case" as an agency proceeding wherein the legal rights, duties or privileges of a party are required by law to be determined by an agency after opportunity for an adjudicatory hearing.

The Court of Appeals ruled first that the petitioner had standing under the state APA to seek judicial review of the state agency's decision exempting its competitor from CON because: (1) the matter was a "contested case" because, although there was no adjudicatory hearing, the state agency knew there was a question whether Wilkesboro was entitled to an exemption and it had a duty to determine that question; (2) as evidenced by the state agency's letter to Wilkesboro and its letter to petitioner denying reconsideration the state agency had reached a "final agency decision" on the case; and (3) petitioner was a "person aggrieved" because as a prospective competitor it had a substantial stake in the outcome of the controversy that would cause it to seek complete review and full adjudication of the issue. The Court then remanded the case to the state agency to conduct a reconsideration hearing, apparently concluding that the requirements for standing to seek reconsideration as a "person aggrieved" were the same as the requirements for standing under the APA to seek judicial review.

(5) Gerte v. Department of Public Health 462 N.E.2d 1112 (Mass. App. 1984)

Several ten-taxpayer groups of area residents brought an action seeking judicial review of a State Health Department decision approving a transfer of ownership of a hospital in their community under the state's facility licensure statute and seeking to compel the Department to conduct an evidentiary hearing. The ten-taxpayer groups argued, among other things, that the transfer should not have been approved because the applicants contemplated substantial improvements to the hospital which were subject to review under the state CON statute. The state CON statute granted ten-taxpayer groups the right to an evidentiary hearing and both administrative and judicial appeal of CON determinations. The licensure law contained no corresponding provisions. The Court held that: (1) the taxpayer groups were precluded from obtaining relief for any alleged error in failing to review the project under the CON statute because they neglected to exhaust their administrative remedy of seeking an administrative appeal under the CON statute; and (2) the taxpayer groups lacked the right to seek judicial review of the Department's determinations under the licensure statute because the groups had neither statutory standing nor a legally cognizable personal interest in the application, and the groups had no constitutional right to a hearing in the circumstances presented.

(6) In re Fort Washington Health Care Center Law No. 91,091 (Md.Cir.Ct. Prince George's County Nov. 19, 1982)

A hospital brought an action seeking judicial review of a state CON administrative appeal agency's dismissal of its attempted appeal of the State agency's decision granting its competitor, an ambulatory care center, a CON modification. State agency regulations providing for project modification review authorized the SHPDA to approve/disapprove a modification or to find the modification to be of sufficient scope to warrant full CON review. The state CON statute and regulations granted an aggrieved party the right to appeal a "decision" of the state agency (Md.Ann. Code Art. 41 §59L (1981 Cum. Supp.); COMAR 10.24.01.17 (1980)) but the CON modification regulations also provided that modification approval/disapproval determinations did not constitute judicially appealable state agency "decisions" (COMAR 10.24.01.14 (1980)). In approving the ambulatory care center modification request, the state agency had allowed a 50% cost increase, 10% sq. footage reduction, change in type of financing, and extension of the construction commencement date, and found these changes insufficient in scope to require full CON review.

The Court held that the state agency acted within its discretion in adopting the regulation excluding modification approval/disapproval determinations from the category of "decisions," thereby barring appeal of modification approvals, noting that the state legislature, which by law had the opportunity to review the regulation and had made no recommendation for change, had approved the rule sub silentio.

(7) Sisters of Providence in Washington, Inc. v. Dept. of Health and Social Services 648 P.2d 970 (Alaska 1982 modified Sept. 30, 1982)

A hospital brought an action seeking judicial review of a state agency decision that the grandfather exemption of its crosstown competitor's project to construct a new facility had not expired because the project had been substantially implemented. Construction on the project had been stalled at the initial ground preparation and foundation stage due mainly to financing problems. The statutory grandfather clause provided that projects under construction before a specified date were entitled to a CON. State regulations provided that the CON would expire after a specified period of time if the project were not "substantially implemented", and set forth general criteria for substantial implementation (Alaska Admin. Code §07.090(d), (e), (f)). The regulations did not set forth specific procedures for making the decision that a project had been substantially implemented, nor did the CON statute or regulations provide for judicial review of such decisions, but they did permit substantially or directly affected parties to appeal CON decisions and to bring enforcement and CON revocation actions.

At the competitor's request and following notice and receipt of comments by interested parties, such as the plaintiff, the state agency issued a decision that the project had been substantially implemented. The hospital then brought this action.

In the course of upholding the state agency decision, the Court held that: (1) The state agency's decision was subject to judicial review notwithstanding the absence of a statutory provision for review. There is a general presumption of reviewability of administrative decisions, and the statutory and regulatory provisions for CON revocation and enforcement do not indicate that they are intended to be exclusive remedies. (2) The hospital had standing to bring the action because: (a) It had a sufficient personal stake in the outcome of the controversy since the proposed hospital would be its direct competitor and the extension of the exemption would inhibit its efforts to obtain a CON to expand its facilities. The Court rejected the argument that the hospital's allegations of future harm were too speculative because under hypothetical future conditions the project would not be constructed and because the hospital did not have its own expansion CON application pending. It ruled that threatened future harm sufficed for standing and that, given the time limits for appeal from administrative decisions, the adverse effects of a CON approval will almost always be based on future events. The Court also rejected the argument that the hospital should be denied standing because a CON revocation proceeding was pending against the competitor's project. It concluded that the revocation proceeding would not adjudicate the "substantial implementation" issue raised in the plaintiff's case. (b) The hospital was granted standing by law and regulations to seek review of other CON determinations and these provisions illustrated a legislative recognition of its interest in the state agency's decisions.

(8) Detroit-Macomb Hospitals Association v. Milliken No. 82-28861-CZ (Mich.Cir.Ct. Ingham County April 14, 1982)

A hospital brought an action challenging the adoption of the State Bed Reduction Plan, an institution-specific CON review criterion. The Plan was incorporated into the State Health Plan, consistency with which is a CON review criterion. The hospital was targeted for closure under the Bed Reduction Plan. The Court held that the hospital had standing to challenge the plan even though it did not have an application pending to which the plan had been applied. It concluded that the plan had a direct effect on the hospital's legally protected interests because: (1) at the moment the Bed Reduction Plan was adopted the future viability of targeted hospitals was destroyed; and (2) public knowledge that a particular hospital was slated to be closed would cause numerous irreparable harms.

(9) *Village of Herkimer v. Axelrod* 462 N.Y.S.2d 633 (Ct. App. 1983), *aff'g. on other grounds*, 451 N.Y.S.2d 303 (App. Div. 1982)

A municipality which operated a local public hospital brought an action seeking to enjoin as unconstitutional state proceedings to modify the hospital's operating certificate to convert it from an acute care hospital to a long-term care facility. The lower court upheld the state's action, ruling that the operating certificate modification statute's criteria were not void for vagueness; that the conversion was not the kind of destructive restriction on use that amounts to a compensable taking; and that the modification statute was not preempted by NHPRDA under the Supremacy Clause.

The municipality was empowered to operate the hospital by a state law establishing municipalities as political subdivisions of the state. On appeal, the Court of Appeals held that the municipality lacked standing to maintain its constitutional challenges to the modification statute because the hospital was operated as part and parcel of the municipality's authority as a political subdivision and political subdivisions were powerless to challenge the constitutionality of an act of the legislature restricting their governmental powers. The Court also noted that the municipality's other claims had been considered and found to be without merit.

(10) *Balsam v. Dept. of Health and Rehabilitative Services* No. AV-436 (Fla. Dist.Ct.App. June 13, 1984)

Proponents of a psychiatric hospital construction project brought an action challenging the validity of a SHPDA moratorium on CON reviews and apparently seeking an order compelling the SHPDA to review their CON application in a particular batching cycle. At the time plaintiffs filed their application the SHPDA had administratively imposed a time-limited moratorium on CON reviews for the stated purpose of allowing it time to promulgate rules on statewide bed-need methodologies required by recent legislation. The SHPDA informed plaintiff that it could re-file an application to be processed in the first post-moratorium batching cycle. The state CON statute required the SHPDA to review CON applications in no less than four batched reviews per year and the SHPDA had adopted batching cycle regulations. The Court held that: (1) the controversy was not moot on the grounds that the moratorium had expired, nor did plaintiffs lack standing to challenge the moratorium on the grounds that they had not lost any competitive advantage, because imposition of the moratorium affected their substantial interests.

5. Exhaustion of Administrative Remedies/Interlocutory Appeals

a. Section 1122 Cases

(1) Canonsberg General Hospital v. Commonwealth Dept. of Health 422 A.2d 141 (Pa. 1980), rev'g, 413 A.2d 1185 (Pa.Cmwlth. 1980)

A hospital brought an action seeking by way of a writ of preemptory mandamus to obtain review of the decision of the DPA refusing to declare complete its application under Section 1122 to construct a new hospital and seeking a court order that the DPA declare the project "deemed approved." The Court held that the hospital failed to exhaust its administrative remedies when it brought this action before pursuing an administrative complaint mechanism which was available to it under state law.

(2) Lynch Medical Services, Inc. v. State Comprehensive Health Planning Council 27 K.L.S. 9 (Ky.Ct.App. May 16, 1980)

A competitor brought an action to enjoin the DPA from recommending approval for reimbursement under Section 1122 of a project to construct a primary care center. The Court held that: (1) a competitor could bring an action in state court seeking such relief, (2) the plaintiff had exhausted all avenues of administrative review available at the state level, and (3) the plaintiff's failure to request a reconsideration by the Secretary of HHS of his determination regarding the project did not constitute a failure to exhaust administrative remedies.

(3) Cf. Citizens General Hospital of New Kensington, Pennsylvania v. Commonwealth Department of Health 430 A.2d 393 (Pa.Cmwlth. 1981.)

A hospital brought an action seeking an order directing the DPA to "deem approved" its application for reimbursement under Section 1122 of a capital project. The DPA had declared the project complete, prepared a proposed negative recommendation to the Secretary of HHS, and rejected the hospital's arguments that the project should be deemed approved for failure of the DPA to timely approve. (See 42 CFR §100.106(a)(4)). These DPA actions had been upheld in administrative appeals brought by the hospital. The hospital had then unsuccessfully attempted to appeal the disapproval on the merits to Court but the Court had refused to hear the appeal on the authority of Sarah A. Todd Memorial Home v. Department of Health. The hospital then brought this action. The Court held that the hospital could maintain the action because: (1) it had exhausted its administrative appeal remedies (Compare Canonsberg General Hospital v. Department of Health, supra.); (2) Sarah Todd was not a bar because the hospital was not appealing the negative recommendation itself but instead seeking to have the application deemed approved; and (3) it was not required to have pursued its federal administrative remedy of seeking a reconsideration of a determination by the Section of HHS (Section 1122(f), 42 USCA §1320a-1(f)) because the action was brought to require the state to deem the application approved, not to review a decision by the Secretary of HHS.

(4) Nazareth Literary and Benevolent Institution, Inc. v. W. Grady Stumbo No. C-81-0637 L(A) (W.D.Ky. Dec. 4, 1981)

A hospital brought an action seeking to enjoin submission to HHS of a DPA decision, affirmed by a designated hearing officer, recommending denial of reimbursement under Section 1122 of its project to construct a new long-term care facility. The 1122 regulations require that the hearing officer notify the person requesting the hearing of his decision not more than 45 days after the conclusion of the hearing, with an untimely notification deemed an approval (45 CFR §100.106(c)(3)). The petitioner's hearing concluded on August 25, 1981. The mailed decision was postmarked October 13, 1981 and received by petitioner's attorney on October 14, 1981, 50 days after the hearing ended. The 1122 regulations also require a DPA to establish and maintain 1122 notification and review procedures (42 CFR §100.106). The DPA had not done so.

The Court held that the petitioner had not failed to exhaust its administrative remedies before bringing this action because: (1) there were no further administrative remedies available at the state level [the Court apparently did not consider the Secretary of HHS' determinations under the Section 1122 review scheme to be "administrative remedies"]; and (2) the issues involved were questions of law, for which exhaustion is not required.

(5) Luzerne County Medical Society v. Commonwealth of Pennsylvania, Department of Health No. 2014 C.D. 1980 (Pa. Cmwlth. Dec. 31, 1981)

A medical society brought an action in mandamus seeking to compel the DPA to notify DHHS that a particular health care facility had undertaken capital expenditures without giving the DPA 60-day prior notification as required by Section 1122. The Court dismissed the action for failure to exhaust administrative remedies because the medical society failed to pursue an administrative complaint mechanism which was available to it under state law. The Court thus followed Cannonsberg General Hospital supra.

(6) Lifemark v. Guissinger 446 So.2d 1279 (La. 1982)

A hospital brought an action seeking judicial review of a DPA decision making findings recommending approval under Section 1122 of its competitor's project to construct a new hospital and judicial review of the DPA decision recommending denial of its own similar project. The federal Section 1122 statute and regulations (which the state 1122 regulations repeated) required the DPA to grant to a person proposing a capital expenditure the right to an administrative appeal, which right must be exercised within 30 days after the date on which the person proposing the capital expenditure receives notice of an adverse finding or recommendation. (42 U.S.C.A. §1320a-1(b)(3); 42 CFR §§100.106(c), (c)(1)).

The Court held that judicial review of the denial of the plaintiff's application was barred by the doctrine of exhaustion of administrative remedies because: (1) the 1122 regulations do not contemplate judicial review until such time as the administrative appeal is concluded; and (2) assuming arguendo that the state APA applies to the Section 1122 process (including the state APA provision for judicial review of preliminary, procedural, or intermediate administrative actions if irreparable injury is imminent and no adequate remedy on review of the final agency decision exists) no such irreparable injury or absence of an adequate remedy from the issuance of the negative recommendation was present in this case.

(7) Martin County Nursing Center v. Medco Centers, Inc. 441 N.E.2d 964 (Ind. App. 1982)

A nursing home brought an action seeking to reinstate a DPA hearing officer's decision making findings recommending approval under Section 1122 of its project to construct a new 60 bed nursing home. The nursing home (Martin) had filed an 1122 application competing with that of Medco (the existing facility in the area which proposed a replacement/expansion project). The State Health Plan projected a bed need in the area which the Medco project would satisfy and which the Martin project would exceed. A witness at the fair hearing testified that notwithstanding the Plan projection there was an areawide need for the number of beds which the Martin project proposed. The hearing officer relied upon this testimony, among other things, in ruling in favor of Martin and against Medco. With respect to the need criterion the trial court which heard Mecdo's petition for judicial review relied exclusively on the Plan and ruled against Martin. The Court noted that Medco's petition for judicial review of the hearing officer's decision would not be barred by the doctrine of exhaustion of administrative remedies (on the grounds that the final decision on an 1122 application rests with the Secretary of DHHS) because the Secretary has mere ministerial duties when the DPA has approved the application and the Secretary lacks discretionary power to override the decision of the DPA once it has approved, by proper procedure, a proposed capital expenditure.

(8) Humana Hospital Corp., Inc. v. Blankenbaker 734 F.2d 328 (7th Cir. 1984)

Humana brought an action in federal court seeking to enjoin submission to DHHS of a DPA decision, affirmed by a state hearing officer, recommending denial of reimbursement under Section 1122 of its project to construct a new hospital. Humana alleged that the DPA had failed to follow various procedural requirements of federal 1122 regulations and that the DPA's decision was not supported by substantial evidence. The Court held that the complaint should be dismissed for lack of jurisdiction due to Humana's failure to exhaust its administrative remedies of DHHS determination of reimbursement and DHHS reconsideration because: (1) further administrative action by the Secretary of DHHS, who has authority to review state agency compliance with Section 1122 [compare Hollingsworth v. Schweiker] and to grant reimbursement despite a negative DPA recommendation, may result in resolution or refinement of the issues at the agency level without unnecessary expenditure of judicial resources; and (2) denial of judicial review will avoid a constitutional conflict between branches of government arising out of the prospect of DHHS review of the Court's decision. [See 42 C.F.R. §100.108(d)(2) which provides that the record before DHHS on reconsideration of its initial 1122 determination shall include the record of any judicial proceedings below.]. Citing Hollingsworth v. Harris, the Court also held that Humana would not be barred from seeking judicial review of the further DHHS administrative actions by Section 1122(f), which provides that DHHS determinations under 1122 shall not be subject to administrative or judicial review, because judicial review of the Secretary's compliance with the procedures of Section 1122 and the regulations thereunder is not barred by Section 1122(f).

(9) Psychiatric Institutes of America, Inc. v. Heckler 596 F.Supp. 1311 (E.D.La. 1984)

PIA brought an action seeking to permanently enjoin DHHS from making a favorable determination of reimbursement under Section 1122 for a competitor's psychiatric hospital construction project during the pendency of PIA's action in state court seeking judicial review of the DPA hearing officer's decision approving the project. PIA and the competitor had received 1122 approval for psychiatric hospital construction but neither had built. The Court ruled that PIA was not entitled to an injunction, holding among other things that PIA could not obtain judicial review until it exhausted its administrative remedy of requesting reconsideration by the Secretary of her initial 1122 determination.

b. Certificate of Need Cases

(1) Merry Heart Nursing and Convalescent Home, Inc. v. Dougherty 330 A.2d 370 (N.J.Super. App.Div. 1974)

A nursing home brought an action seeking judicial review of a state CON appeals board decision on its application for a CON to add beds to its facility. The board remanded the application to a state agency hearing officer with directions that the need for the project be reviewed for conformity with the State Plan for Health Care Services as updated shortly after the nursing home's CON application was filed. The state moved to dismiss the appeal on the grounds that the hearing before the hearing officer had not taken place. The Court held that the nursing home was not required to exhaust its administrative remedy of a hearing because: (1) the doctrine of exhaustion of administrative remedies is neither jurisdictional nor an absolute requirement, and (2) the issues raised in this appeal are purely legal, the facts raising the issues being undisputed, and in that situation the interests of justice do not require the exhaustion of administrative remedies.

(2) National Nephrology Foundation v. Dougherty 351 A.2d 392 (N.J.Super.App.Div. 1976)

A hospital brought two actions, consolidated by the Court, appealing the awarding of a CON by the State Commissioner of Health to its competitor to establish a renal dialysis facility and appealing the affirmance by the Health Care Administration Board (HCAB, an administrative appeals body), of the Commissioner's denial of its application to establish a similar facility. The state CON statute and regulations provided that the Commissioner's decision to grant an application was a final one, appealable to court, but the Commissioner's decision to deny a CON was subject to administrative review by the HCAB. The applications had been treated as competing applications from the time of initial review by the area CHP agency. The Court observed in dicta that, notwithstanding the provisions for administrative appeal of CON denials, when parties are essentially competing for the same certificate the disappointed applicant seeking judicial review should seek leave to the court for an interlocutory judicial review of its denial [and, presumably, consolidation of that action with appeal of the granting of the CON to the other applicant - Ed.] The Court can then adjudicate the entire controversy in which the grant of the certificate to the one party is inextricably bound up with the denial of a certificate to the other.

(3) Greenberg v. Hospital of St. Raphael 363 A.2d 768 (Conn.C.P. 1976)

A group of physicians brought an action to enjoin two hospitals from developing ambulatory surgery services without applying for CON's. The physicians had applied for, been denied, and had pending an appeal from the denial of an application to establish a freestanding ambulatory surgery center. [See Temple Street Associates v. Commission on Hospitals and Health Care.] The decision denying their application stated that if the two hospitals had not instituted comparable ambulatory surgery services within four months a reapplication by the physicians would be welcome. The physicians alleged that the hospitals had proceeded to institute such services, that doing so required a CON, and that the state had not acted to require them to apply. The Court held that the state APA gave plaintiff the right to seek a declaratory ruling from the state agency on the applicability of the CON statute to the hospitals, and to appeal such a declaratory ruling to the courts, and that the action should therefore be dismissed for failure to exhaust the administrative remedy of such a declaratory ruling.

(4) Lahey Clinic Foundation, Inc. v. Health Facilities Appeals Board 380 N.W. 2d 675 (Mass. 1978)

A hospital was awarded a CON to construct a new facility in 1972. In 1976 the state agency granted an extension of the project authorizing major changes in square footage, services, and cost. At issue in the various actions involved in this case was whether the "extension" was in substance a new project requiring a new CON. A taxpayer group which considered the project to require a new CON appealed the state agency extension of the project to the Health Facilities Appeals Board. [By law, the Board had administrative appellate jurisdiction over departmental decisions on CON applications. The state law also provided that persons seeking review of cases involving extensions of CON could first seek "departmental review" within the state agency and then judicial review.] The Board first concluded that it had jurisdiction to review the state agency's action as if it were an appeal from the award of a new CON. The taxpayer group which had brought the appeal had by then withdrawn its appeal, but the Board ruled that other persons automatically made parties to the appeal could pursue it, or other taxpayer groups could intervene. At that point the hospital brought this lawsuit to enjoin the Board from hearing the appeal. A second taxpayer group intervened in the hospital's lawsuit and counterclaimed against the hospital for a declaratory ruling that the project required a new CON. A lower court ordered the Board to dismiss the taxpayer appeal on the grounds that the taxpayer group had withdraw its appeal and no other appropriate appellants existed, and ruled on the merits on the counterclaim that the extension did not require a new CON. (1) The Supreme Court held that the lower court erred in ordering the Board to dismiss the appeal because the Board's determination of its own jurisdiction, based on disputed characterizations of facts and concerning such interlocutory procedural questions as who is a party to an administrative appeal, when the withdrawal of such an appeal takes effect, and whether a late petition to intervene should be entertained by the Board, was not a final administrative decision from which judicial review directly or by a writ of prohibition was proper. (2) The Court also held that the counterclaim, thought of as seeking direct review of the department's decision granting an extension, should have been dismissed for failure to exhaust administrative remedies, because the taxpayers failed to pursue "departmental review." (3) Thought of as seeking to resolve the issue of whether the extension was in substance a CON, the counterclaim, [like the hospital's complaint] should have been dismissed as premature, until the Board had had a further opportunity to make a final decision on the appeal. (4) Concluding that the substantive issues had nevertheless been sufficiently presented in the trial court, the Court ruled on the merits that the state agency did not improperly exercise its discretion in granting the extension without requiring a new CON.

(5) Dobbs Ferry Hospital Association v. Whalen 403 N.Y.S. 2d 304 (App.Div. 1978)

A hospital brought an action seeking judicial review of the state agency's disapproval of its application for a project to replace its outdated facilities. The state had notified the hospital that its project was being disapproved on the basis of a lack of public need and informed the hospital of its right to a hearing. The hospital immediately brought this action. The Court held that the hospital did not have to exhaust its administrative remedy of a hearing before instituting this action because the basis for decision given by the state was patently erroneous as a matter of law - the state regulations in effect at the time not providing for disapproval on the basis of lack of need.

(6) Health Resources Foundation v. Dept. of Health 377 N.E.2d 1056 (Ill.App. 1978)

A hospital brought an action seeking to compel the State Department of Health to issue a license for its new facility and seeking to be declared exempt from the state CON statute. The hospital alleged that a particular licensure requirement was arbitrary and discriminatory and that the state had arbitrarily delayed in reviewing its license application. The hospital filed suit before an administrative hearing on its license application occurred. The Court held that the hospital had not failed to exhaust its administrative remedies and therefore could maintain the action because a party need not exhaust his administrative remedies when he attacks a statute or administrative rule on its face.

(7) Southern Indiana Health Systems Agency v. Board of Health 391 N.E.2d 845 (Ind.App. 1979)

An HSA brought an action seeking judicial review of a DPA recommendation approving for reimbursement under Section 1122 a hospital project to acquire a CT scanner. The HSA had initially reviewed the project and recommended denial. Acknowledging that it did not have a cause of action for judicial review under the federal Section 1122 review scheme, the HSA argued that: (1) because the project fell within the definitions of projects required to be covered by a state CON program under NHPRDA, the HSA ought to be able to exercise its administrative appeal right set forth under the Act (Section 1522(b)(13); 42 U.S.C.A. §300m-1(b)(13)), (2) alternatively, the HSA ought to be entitled to the administrative appeal right set forth in NHPRDA when it was acting under Section 1122 because of the provision of the Act requiring the SHPDA to serve as the DPA if the state has an 1122 program (Section 1523(a)(4)(A); 42 U.S.C.A. §300m-2(a)(4)(A)), and (3) because the state had not designated an administrative appeals mechanism pursuant to Section 1522(b)(13) a request for review would be meaningless and therefore the HSA had exhausted its administrative remedies, and (4) therefore the HSA was now entitled to judicial review. The Court held that, assuming for the purposes of argument that the HSA's appeal rights under NHPRDA entitled it to an administrative appeal, the HSA had not shown that a request for review would have been futile because its request could have prompted the state to institute an administrative review mechanism. Therefore, the Court dismissed its action for failure to exhaust administrative remedies.

(8) Texas Health Facilities Commission v. West Texas Home Health Agency 588 S.W.2d 655 (Tex.Civ.App. 1979)

A home health agency brought an action seeking judicial review of a state agency "cease and desist" order issued in an administrative CON enforcement proceeding brought against the HHA by the state agency. The agency alleged that the HHA violated the CON statute by opening six "consultation offices and/or work rooms" in a particular geographical area. The offices consisted of one room with a table, chair, and remote telephone answering service. No medical or other records were kept in the office; no employee manned the office; and no treatment or health care functions were performed in the office. The state CON statute required the HHA to obtain a CON or exemption to: modify an existing facility; convert a structure into a health care facility; or substantially expand a service currently offered, which the state agency had by regulation defined to include establishment of a branch office.

The Court held that the HHA's action was not barred by the doctrine of exhaustion of administrative remedies because the provision of the state statute authorizing persons to seek declaratory rulings form the state agency as to the applicability of the statute to a proposed project, which barred judicial review of the declaratory ruling until after denial of a CON application, did not preclude the Court from reviewing the state agency's "cease and desist" order in an enforcement proceeding brought by the state.

(9) Shenango Valley Osteopathic Hospital v. Dept. of Health of Pennsylvania 451 A.2d 434 (Pa. 1982)

A hospital brought an action seeking: (1) judicial review of a state agency determination that its acquisition of a CT scanner was subject to CON review; (2) declaratory and injunctive relief relating to the constitutionality of the CON statute; and (3) interim special relief permitting it to operate the scanner while its application for a CON to acquire the equipment underwent review by the state and local health planning agencies. Without obtaining a CON, the hospital had purchased and accepted delivery of the $268K scanner in July and August of 1981, at which time the state CON statute covered capital expenditures in excess of $165K. On October 1, 1981 the statute was amended, increasing the capital expenditure threshold to $600K but continuing coverage of any "addition of a health service" regardless of the value of the capital expenditure associated with the health service addition. The state agency then determined that the acquisition was covered as a health service addition and ordered the hospital not to operate the scanner until it obtained a CON. The hospital appealed the agency's coverage determination to an administrative appeals board (the State Health Facility Hearing Board), filed a CON application, and brought this action, in which among other things it raised constitutional objections to the CON statute on vagueness and unlawful delegation grounds.

The Court ruled that the hospital's action was not barred by failure to exhaust administrative remedies because exhaustion is not required where, as here, equitable relief is sought, a substantial question of constitutionality is raised, and there is no adequate administrative remedy. The Court concluded that: (1) no administrative remedy was available because the State Health Facility Hearing Board's express grant of jurisdiction in the state CON statute did not include the authority to pass upon the constitutionality of the CON statute, nor could it be reasonably inferred given the Board's makeup and expertise; and (2) neither were the constitutional challenges within the purview of the state agency.

(10) Village of Herkimer v. Axelrod 451 N.Y.S.2d 303 (App. Div. 1982), aff'd on other grounds 462 N.Y.S.2d 6[illegible] (Ct. App. 1983)

A local public hospital brought an action seeking to enjoin as unconstitutional the state Commissioner of Health's proceedings to modify the hospital's operating certificate to convert it from an acute care hospital to a long-term care facility. The state health planning statute authorized the Commissioner to modify or revoke a hospital's operating certificate after considering the total number of beds necessary to meet the public need and the availability of alternatives and finding that "modifying or revoking the operating certificate of such facility would be within the public interest in order to conserve health resources by restructuring the number of beds and/or the level of services to those which are actually needed." (N.Y. Public Health Law §2806(6)(a)).

The Court ruled that the action was not barred by the plaintiff's failure to exhaust administrative remedies because the plaintiff attacked the Commissioner's action as unconstitutional and wholly beyond his authority and the exhaustion doctrine did not apply to such claims.

(11) Roskey v. Texas Health Facilities Commission 630 S.W.2d 844 (Tex.Civ.App. 1982)

A taxpayer's association brought an action seeking a declaratory judgement that a CON exemption certificate issued to a district hospital was invalid. The application for the exemption certificate was filed on April 25, 1979 and approved on July 26, 1979. Between those dates, on May 17, 1979, a statutory amendment became effective repealing the sole ground on which the exemption certificate was issued.

The Court ruled that plaintiff's action was not barred by the doctrine of exhaustion of administrative remedies because the state statute did not authorize the Commission to grant the relief sought (withdrawal of the exemption certificate) and where the gravamen of plaintiff's complaint is that the Commission exceeded its authority, the exhaustion doctrine does not apply.

(12) Mercy Medical Center v. Idaho Health Facilities Review Board No. L-35732 (Idaho Dist.Ct., Canyon County, July 28, 1982)

A competitor brought an action seeking to overturn the decision of the Idaho Health Facilities Review Board (the state's CON decision-maker) awarding a CON to its competitor to construct an ambulatory surgicenter. The Review Board had initially voted to deny the application. On administrative appeal an Appeals Board had remanded the decision for a new vote, because the Review Board members failed to affirm when voting that their vote was based solely on the record, as required by Review Board regulations. Then, on remand the Review Board reversed itself and approved the application. The Court upheld the Board's decision, holding among other things that the plaintiff failed to exhaust its administrative remedy of appealing the Review Board's second decision to the Appeals Board. The Court nevertheless reached the issues raised by the plaintiff.

(13) Mercy Hospital v. Commonwealth Dept. of Health 450 A.2d 761 (Pa. Cmwlth. 1982)

A hospital brought an action seeking judicial review of a state agency decision that its project to consolidate ten licensed but unused med/surg beds into a dedicated rehabilitation unit was subject to CON review as an "addition of a health service having an operating expense in excess of [the applicable threshold]." The hospital had appealed the coverage determination to the State Health Facility Hearing Board, an administrative appeals board, which affirmed the Department's decision and dismissed the Hospital's appeal. The Court held that the hospital's appeal to it should be quashed as premature because the determination of reviewability was not a final order but rather an inseparable subsidiary aspect of the main cause of action-the Department's CON review of the project-reviewable, if the hospital desired, after the Department's decision on the application. A dissenting opinion argued that the administrative decision before it was the Board's final decision on reviewability and that if review were permitted to proceed the hospital's claimed right to exemption from review would be bypassed.

(14) Baptist Hospital, Inc. v. Humana of Kentucky, Inc. 672 S.W.2d (Ky. App. 1984)

A competitor (Baptist) brought an action seeking declaratory and injunctive relief and challenging the approval of its hospital competitor's 1982 CON application for renovation/service expansion (Humana). In 1981 Baptist and Humana had filed competing bed addition/service expansion projects which were administratively denied. Humana's 1982 application was identical to its 1981 application except that it requested no additional beds. Baptist did not participate in the administrative proceedings on Humana's 1982 application, although it had the right as an affected health care facility in the area to do so under state law. The Court held that: (1) Baptist was precluded from seeking judicial relief because it failed to exercise and exhaust its administrative remedy of participating in the administrative proceedings on the 1982 Humana application; and (2) Baptist alleged that the state's administrative appeals board's approval of the 1982 Humana application was in excess of the board's jurisdiction because the board's decision was inconsistent with the SHP. It further claimed that its allegation raised a question of law to which the doctrine of exhaustion of administrative remedies did not apply. The Court rejected this claim, holding that whether the board's decision complied with the "consistency with SHP" review criterion had nothing to do with jurisdiction and was reviewable by appeal, not by a declaratory judgment action.

(15) Colorado Health Facilities Review Council v. District Court 689 P.2d 617 (Colo. 1984)

Several hospitals brought an action seeking judicial review of a state CON administrative appeals board's interlocutory order setting aside its hearing officer's initial decision on administrative appeal of a state agency denial of the hospitals' CON applications. The hearing officer's initial decision had reversed the state agency, ruling that it improperly employed a 1985 planning horizon for calculating future bed need rather than a more reasonable 1990 horizon. On a competitor's petition, the board set aside this ruling and remanded to the hearing officer. The state APA provided for judicial review of "final agency action." The Court ordered the hospitals' action dismissed, holding that the board's interlocutory order was not a final agency action subject to review because: (1) it did not determine particular rights in an adjudication; and (2) interlocutory judicial review would not resolve all likely issues respecting the CON applications but would result in inefficient multiple, piecemeal judicial reviews encroaching on the agency's functions. The Court also held that the board's order was not a non-final agency action qualifying for exceptional interlocutory judicial review because: (1) the fact that the board's order decided a question of law did not necessarily require immediate judicial review; and (2) interlocutory judicial review of agency action is appropriate if a party faces irreparable injury from such action but expense from undergoing CON review and delay in obtaining authorization to build have never been considered irreparable injuries. The Court also noted that neither the hospital's general allegations of constitutional violation nor an APA provision authorizing actions to compel administrative agencies to act without undue delay were grounds for interlocutory judicial review.

6. Means of Seeking Review

a. Introductory note

The choice of the proper pleading or procedural mechanism for requesting judicial review of a CON or Section 1122 decision is determined by consulting the state law of civil procedure. There is considerable variation from state to state in the identity of the mechanism for judicial review, though typically review is by way of a writ of administrative mandamus provided for by the state Administrative Procedure Act.

In some states the choice of the proper form of action to proceed under may not be clear, particularly if there have been few cases involving judicial review of CON or Section 1122 decisions in the state (*See, e.g.*, *General Care Corporation v. Forehand* 329 So.2d 49 (Fla.Dist.Ct.App. 1976) and *Page v. Capital Medical Center* 371 So.2d 1087 (Fla.Dist.Ct.App. 1979)). State courts vary on how strictly they require an action to be correctly pleaded. Sometimes more than one means of review is available, and the choice may affect venue, calendar status, and the type of relief the court can grant. It should be apparent that the services of a lawyer familiar with state law are indispensible for dealing with these matters.

7. Availability of Attorney's Fees

a. *Canterbury Nursing Home, Inc. v. Alabama State Health Planning and Development Agency* No. 81-457 (Ala.Sup.Ct. Jan. 28, 1983)

A nursing home brought an action appealing a trial court denial of its request for attorneys' fees. Culminating a dispute on the matter between it and the nursing home, the SHPDA had brought an action seeking a declaratory judgement that the proposed sale of all of the stock of the nursing home was a transfer of a certificate of need prohibited under the state CON statute. The nursing home answered and filed a counterclaim pursuant to 42 U.S.C. §1983 alleging that the SHPDA's interference with its proposed sale was in violation of its rights under the Fifth Amendment and seeking, *inter alia*, injunctive relief and attorneys' fees under 42 U.S.C. §1988. Finding the sale permissible under the CON law, the trial court enjoined the state from prohibiting the sale and denied attorneys' fees on the basis that the nursing home had prevailed on state, not federal law grounds and that special circumstances justified denial of attorneys' fees. The Supreme Court reversed, holding that: (1) an award of attorneys' fees under 42 U.S.C. §1988 is appropriate because: (a) injunctive relief was granted as requested in the counterclaim; (b) there was no indication that the SHPDA would have filed the declaratory judgement action until the nursing home threatened a Section 1983 suit; (c) although the trial court tied the injunctive relief to the declaratory judgement action, there was no indication that the counterclaim did not influence the determination to grant injunctive relief and the trial court did not dismiss the counterclaim; and (2) the trial court's findings: (a) that the SHPDA acted in good faith; (b) that the nursing home had the financial ability to pay attorneys' fees and expenses; and (c) that it would be unjust to put the burden of attorneys' fees on the state and ultimately the public did not together constitute special circumstances rendering an award of attorneys' fees unjust.

B. SUBSTANTIVE ASPECTS OF JUDICIAL REVIEW OF CON/1122 DECISIONS

1. Standards of Review

a. Introductory Note

In many of the judicial opinions reviewing final state agency decisions on CON applications the Courts recite or briefly discuss the standard of judicial review of administrative agency decisions applied in their jurisdiction. (*See, e.g.,* *Nueces County Hospital District v. Texas Health Facilities Commission* 576 S.W.2d 908 (Tex.Civ.App. 1979); *St. Vincent's Hospital v. Finley* 380 A.2d 1158 (N.J.Super.App.Div. 1977); *West Virginia Health Systems Agency, Inc. v. State Health Planning and Development Agency of the West Virginia Department of Health* Civ. No. AP-CA-80-1 (W.VA.Cir.Ct. Kanawha County July 2, 1980); *Nehlich v. South Dakota Comprehensive Health Planning Agency* 290 N.W.2d 447 (S.D. 1980); *Northwest Hospital v. Illinois Health Facilities Planning Board* 375 N.E.2d 1327 (Ill. App. 1978); *Texas Health Facility Commission v. Charter Medical-Dallas* 665 S.W.2d 446 (Tex. 1984). The standards vary somewhat from jurisdiction to jurisdiction, often more in the particular formula of words used to describe them than in the basic nature of the judge's inquiry into the propriety of the decision below. In some but not all states the standard of review is codified in the state Administrative Procedure Act, or in the statute providing for the writ of administrative mandamus or review. Essentially all the standards of review are variations on the so-called "substantial evidence" test in which the court does not independently weigh the evidence and reconsider the factual findings but instead considers whether the administrative decision is supported by substantial evidence in the record. "[J]udgment calls are the province of the administrative tribunal and not of the courts." *Mercy Health Center v. State Health Facilities Council* 360 N.W.2d 808 (Iowa 1985). The inquiry may also be framed negatively as a review of whether the agency decision is "arbitrary, capricious, and unreasonable." The principles underlying the standards of judicial review of administrative decisions are the same everywhere: a balancing of judicial deference to the assigned role and expertise of the agency with judicial protection of individual rights from administrative overreaching.

b. Los Alamitos General Hospital v. Lackner 86 Cal.App. 3d 417, 149 Cal.Rptr. 98 (1978)

A hospital brought an action seeking judicial review of a state agency decision denying its application for an exemption from CON of its proposed remodeling and replacement project. State law provided that where administrative decisions substantially affect fundamental, vested rights the courts should exercise their independent judgment on the evidence in reviewing the decisions and find an abuse of discretion if the administrative findings were not supported by the weight of the evidence. On the other hand, decisions not substantially affecting a fundamental vested right are judicially reviewed to determine whether or not the administrative findings are supported by substantial evidence in light of the whole record. The Court held that: (1) the right to an exemption asserted by the hospital was not vested or fundamental because: (a) the hospital had no vested right to operate free reasonable governmental rules, and (b) the right asserted was the economic privilege to expand and the hospital could continue to operate even if the privilege to expand were denied, and (2) therefore, the applicable standard of review is the substantial evidence test.

c. Texas Health Facilities Commission v. Nueces County Hospital District 581 S.W.2d 768 (Tex.Civ.App. 1979)

A hospital brought an action appealing the granting of a CON to acquire a CT scanner to its competitor and the denial of its application. [The trial court severed the two cases of action. This case concerns the hospital's appeal of the denial of its application. The appeal of the award to the competitor is considered in Nueces County Hospital District v. Texas Health Facilities Commission 576 S.W.2d 980 (Tex.Civ.App. 1979)-Ed.] The Court indicated the appeal was governed by the "substantial evidence" standard of review. All the evidence in the record was that there was a need for two scanners; no witness testified that only one scanner was needed. The state agency acknowledged this fact but argued that it had the authority to utilize its special skills and knowledge in evaluating the evidence. The Court overturned the state agency denial because the state agency had failed to explain the role played by such special skills and knowledge in the findings and a valid exercise of agency expertise, like other agency action, must find support in substantial evidence in the record made before the agency.

d. Samuel Merritt Hospital v. Advisory Health Council 1 Civ. 48646 (Ca.Ct.App. Mar. 27, 1981)

A hospital brought an action seeking judicial review of a state agency denial of its application for a CON to acquire a CT scanner. The state statute required applicants to demonstrate need for CT scanners by "clear and convincing evidence." The Court held that the standard of judicial review was whether the state agency decision that the applicant hospital did not show a need by clear and convincing evidence was supported by substantial evidence. The standard of review was not whether the state agency decision was supported by substantial evidence. Thus, even if it were reasonable to conclude that a need had been shown, but by less than clear and convincing evidence, the state agency decision should still be upheld.

e. Rehab Hospital Services Corp. v. Health Systems Agency of Southwestern Pennsylvania 475 A.2d 883 (Pa. Cmwlth. 1984)

A hospital and a state Health Department brought an action seeking judicial review of a state CON appeals board's decision overturning the Secretary of Health's approval of the hospital's CON application to construct a rehabilitation hospital. The Secretary's approval, which was inconsistent with the recommendation of the HSA and the SHPDA staff, was based in part on project per diem costs lower than existing facilities and was intended to foster competition in an area where rehabilitation services were often provided in acute care hospitals at a much greater cost. The state CON statute contained an express legislative purpose to, among other things, encourage innovation and improved delivery methods. It also required that all Health Department decisions be based solely on the record. The Court held that the fact that the Secretary's decision was based on policy considerations and his own subjective knowledge and years of experience did not mean that it was improperly based on extra-record matters because the Secretary was expected to utilize the experience and background for which he was chosen for office. His use of subjective knowledge would not render his decision improper if the decision was based upon information present within the record. Compare Texas Health Facilities Commission v. Nueces County supra.

f. Beatrice Manor, Inc. v. Dept. of Health 362 N.W.2d 45 (Neb. 1985)

A long-term care facility brought an action seeking judicial review of a state agency decision denying its application for a CON to add 23 beds to its facility. The application was denied in part on the basis of community need measured by the state agency's regulatory need formula. The Court affirmed the state agency decision. In doing so, the Court refused to consider an alternate bed need methodology urged by the facility, ruling that for the Court to sit as a super-administrative agency and substitute the applicant's methodology over the agency's would violate separation of powers doctrine.

g. Collier Medical Center, Inc. v. Dept. of Health and Rehabilitative Services 462 So.2d 83 (Fla.Dist.Ct.App. 1985)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a certificate of need to construct a new hospital which would serve two counties. The Court upheld the state agency decision, holding among other things that with respect to the community need criterion there was conflicting expert testimony in the record and the decision regarding which expert's testimony should be accepted rested with the state agency, not the court.

2. Burden of Proof on Judicial Review

a. Texas Health Facilities Commission v. Nueces County Hospital District 581 S.W.2d 768

A hospital brought an action appealing the denial of its application for a CON to acquire a CT scanner and approval of its competitor's application. The Court observed that the hospital, as an applicant, had to produce evidence in the agency hearing showing a need in the community for a scanner at its hospital and, because the state agency refused its application, it was the hospital's burden on judicial review of the administrative agency decision to demonstrate that the state agency's refusal to make a finding of need for the scanner arbitrary and capricious.

3. Proper Form of Judicial Relief From Erroneous Decision

a. Texas Health Facilities Commission v. Baptist General Convention 573 S.W. 2d 575 (Tex.Civ.App. 1978)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to add five upper floors to an existing hospital building to be shelled-in for later completion. The trial court overturned the state agency denial and remanded the matter to the agency with instructions to approve and grant a CON. The Appellate Court held that the Trial Court did not err in ordering the granting of a CON. It ruled: A court does not have the authority to substitute its judgment for the agency on a matter involving the exercise of discretion by the agency. However, where there are no further discretionary proceedings necessary, as was the case here, it was not improper for the Court to remand the case with instructions to the agency to perform the non-discretionary act of granting the applicant a CON.

b. Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission 312 N.W.2d 422 (Mich.App. 1981)

A hospital corporation (HVH) brought an action seeking judicial review of a state CON administrative appeals agency's decision denying its application for a CON to construct a new hospital in Pontiac, Michigan. Shortly after the denial of HVH's application the state agency had received a Notice of Intent to apply for a CON from the existing hospital in Pontiac to totally remodel its facilities. By the time the Commission heard HVH's appeal, the state agency had approved the existing facility's application. HVH obtained a preliminary injunction against issuance of the CON to the existing facility while it brought this action appealing the denial of its application and alleging that the state agency should have comparatively reviewed the two applications as mutually exclusive, competing applications. In Huron Valley Hospital, Inc. v. Michigan Department of Public Health 284 N.W.2d 758 (Mich.App. 1979) the Court dissolved the preliminary injunction, concluding that both applications could be approved and therefore no irreparable harm to HVH would occur if the existing facility obtained its CON. Subsequently, in this case, the Court concluded that the two applications were in fact mutually exclusive competitors for the same CON and should have been comparatively reviewed. However, it ordered a CON issued to HVH rather than a remand to the agency, noting that: (1) during the pendency of the litigation the scope and purpose of the CON statute had changed, and (2) since only one of the competing applications can be approved and the existing facility's application had already been approved, the decision of the state agency on remand would suffer from the same problem as its original decision.

c. Humana Medical Corporation v. Schweiker No. 81-459-N (M.D. Ala. July 14, 1982)

A hospital brought an action against DHHS and Alabama State officials seeking to overturn a DHHS one-year exclusion for lack of timely notice of reimbursement under Section 1122 for costs associated with a cost overrun in the hospital's renovation/expansion project. The hospital raised several issues concerning exemption of its project under 1122, the DPA's authority to review, procedural errors by DHHS and the DPA, etc. dealt with elsewhere in the GUIDE. The Court held that the hospital failed to state a claim upon which relief can be granted against the state defendants (the state governor and health department director) because: (a) money damages against them in their official capacities are barred by the Eleventh Amendment and are barred against them in their individual capacities by the fact that they were not in office at the time of, or not involved in, the DPA actions complained of; and (b) declaratory and injunctive relief against the State and its officials cannot be granted because Alabama no longer participates in the 1122 program.

d. Cf. Wisconsin Hospital Association v. State Dept. of Health, et al. No. 82-CV-2653 (Wisc.Cir.Ct., Dane Cty., Mar. 8, 1983)

A hospital association brought an action seeking a declaratory judgement that the state's statutory CON moratorium conflicted with NHPRDA and thus was unconstitutional under the Supremacy Clause; and that the informal procedures used by the SHPDA to administer the moratorium were invalid because not formally promulgated as regulations.

The Court ruled that the "Procedures for Moratorium Implementation", a SHPDA document containing guidelines for calculating coverage and exemptions from the moratorium, was an agency statement of general policy required to be promulgated by regulation. However, the Court refused to order the SHPDA to accept and process all CON applications, regardless of whether they were covered by the moratorium, until such time as regulations were adopted because the legislature did not require promulgation of rules in order to interpret and implement the statute and the statutory provision for the moratorium is clear and self-executing.

e. Balsam v. Dept. of Health and Rehabilitative Services 452 So.2d 976 (Fla.Dist.Ct.App. 1984)

Proponents of a psychiatric hospital construction project brought an action challenging the validity of a SHPDA moratorium on CON reviews and apparently seeking an order compelling the SHPDA to review their CON application in a particular batching cycle. At the time plaintiffs filed their application the SHPDA had administratively imposed a time-limited moratorium on CON reviews for the stated purpose of allowing it time to promulgate rules on statewide bed-need methodologies required by recent legislation. The SHPDA informed plaintiff that it could re-file an application to be processed in the first post-moratorium batching cycle. The state CON statute required the SHPDA to review CON applications in no less than four batched reviews per year and the SHPDA had adopted batching cycle regulations. The Court held that the moratorium was an agency rule, invalid since not formally adopted as a regulation, because it was a statement of general applicability consistently applied to all applications during the time it was in force. However, the Court concluded that its determination that the moratorium was an invalid rule did not require the SHPDA to automatically issue a CON to plaintiff, but did require the SHPDA to process its application as soon as possible.

f. Princeton Community Hosp. v. State Health Planning 328 S.E.2d 164 (W.Va. 1985)

Two hospitals brought consolidated actions seeking judicial review of state agency decisions denying their applications for bed addition/expansion CONs. A trial court had reversed the state agency and granted CONs without remanding to the agency. The Court reversed, upholding the state agency decision. The Court noted that the trial court erred in granting the CONs without remanding to the agency for review and findings relating to need criteria because in doing so the trial court improperly exercised independent judgment on the evidence, exceeding its limited jurisdiction under the state APA to review agency determinations.

4. Deference to Agency Interpretation of Governing Law

a. Texas Health Facilities Commission v. El Paso Medical Surgical Associates 573 S.W. 2d 291 (Tex.Civ.App. 1978)

A medical group which had been granted a CON to establish a day surgery outpatient center brought an action seeking judicial review of a state agency refusal to transfer the CON to a hospital, with the center to be relocated in the hospital. The state CON statute permitted CONs to be transferred for good cause. The state agency concluded that the good cause CON transfer provisions should not be interpreted to permit a transfer involving a relocation. In upholding the state agency decision the Court held that where the meaning of a statutory provision is unclear, in doubt, or ambiguous, the construction placed upon it by the agency charged with its administration is entitled to great weight. Although the courts are not bound to do so, the Court should give deference to the agency construction and when the construction of an administrative regulation rather than a statute is in issue deference is even more clearly in order.

5. Identity of the Final Decision Subject to Review

a. Which State-Level Decision?

(1) Olathe Hospital Foundation v. Extendicare, Inc. 539 P.2d 1 (Kan. 1975)

Several hospitals brought an action seeking judicial review of a state agency appeals panel's final decision granting a CON to their competitor to construct a new hospital. The state statute provided that the first decision on a CON application was made by a regional planning agency. It then provided for appellate review of the regional planning agency decision by an administrative "appeals panel" which was granted the authority to approve or disapprove the application. The Court held that on judicial review of an administrative decision on a CON application the trial court was to review the decision of the "appeals panel," not the decision of the regional planning agency, because the appeals panel had the authority to exercise its own judgment on an application.

([illegible]) Bureau of Community Medical Facilities v. Samson 341 So.2d 1071 (Fla.Dist.Ct.App. 1977)

A DPA brought an action seeking judicial review of the decision of a hearing officer reversing the DPA's recommendation of denial of reimbursement under Section 1122 of a project to construct a new hospital. The state's Section 1122 contract required the DPA to comply with the federal Section 1122 regulations including providing disappointed applicants with a fair hearing before a hearing officer whose decision superceded the findings and recommendations of the DPA (42 CFR §100.106(c)(2), (4)(1976)). The state APA provided for judicial review of "final agency action." The DPA had not adopted the hearing officer's decision as its decision.

The Court held that judicial review of the hearing officer's decision was not available because the decision was not a final agency action. The Court indicated that the DPA had to take final action either by recommending denial (in which case, the Court observed, it would violate the Section 1122 contract provision that the hearing officer's decision supersedes the DPA's determination) or by recommending approval, contrary to its true position. If it recommended approval, the Court noted that it could not seek judicial review as a "person adversely affected."

(3) In re Certificate of Need Application by Bethany Medical Center 630 P.2d 1136 (Kan. 1981)

The State Department of Health and Environment brought an action appealing the decision of the Kansas Corporation Commission (the administrative agency which heard administrative appeals from Health Department CON decisions) reversing the Department's decision denying a hospital's application for a CON to acquire a linear accelerator. The Department argued that the decision to be reviewed by the Court was its decision to deny, not the Commission's decision to approve. The Court disagreed, and held that under state law and the federal health planning regulations ("which the state agencies are required to follow in order to comply with federal standards") the Commission's decision was the final decision reviewable by the courts.

(4) Hale v. Petit 438 A.2d 226 (Me. 1981)

Two competitors applied for a CON to construct an intermediate care facility. One was approved. The disappointed applicant appealed the denial of its application and the concurrent granting of a CON to the other applicant. The statutory state CON process entitled an applicant to a public hearing at the HSA but not to an administrative hearing at the state level. Following the HSA hearing and recommendation the state agency issued a decision on the application. Reconsideration of a state agency decision was granted for good cause shown. The disappointed applicant requested and was denied a reconsideration, whereupon it sought judicial review of the "final agency action." The Court held that the state agency decision to deny the request for reconsideration was the final agency decision subject to judicial review, not the state's initial decision to grant or deny the application. However, the plaintiff suffered no prejudice from this limitation on review since the plaintiffs could raise in their request for reconsideration any issue which they would have been able to raise on direct appeal of the decision to issue or deny a CON, were such direct review possible, provided that failure to raise an issue in the reconsideration request would foreclose judicial review of that issue.

(5) Fahey v. Public Health Council 453 N.Y.S.2d 824 (App. Div. 1982)

A person seeking to acquire and establish a nursing home brought an action appealing the Public Health Council's denial of its application. Under the state certificate of need/licensure statute such a facility may not be established without the approval of the Council. If the Council proposes to disapprove the application, it must offer the applicant the opportunity to request a public hearing which may be conducted by a Council-designated hearing officer. After proposing to deny and granting the applicant a hearing in this case, the Council denied the application notwithstanding the hearing officer's findings and conclusions recommending approval.

The applicant contended that the Council was required to adopt the findings and conclusions of its hearing officer unless the findings were not based on substantial evidence. The Court held that this argument was without merit because the Council, not the hearing officer, is authorized by the statute to determine the application. It is the Council's determination, not the hearing officer's report, which must be supported by substantial evidence.

(6) Cf. Iowa Health Systems Agency, Inc. v. Wade 327 N.E.2d 732 (Iowa 1982)

An HSA and a DPA brought an action seeking judicial review in state court of a hearing officer's decision making findings recommending approval of reimbursement under Section 1122 for a project to replace an existing facility. The hearing officer had reversed the negative recommendation of the DPA, which was based on the hospital's failure to satisfy the need, economic feasibility, and cost effectiveness criteria, for lack of substantial evidence. The Court reversed, holding that although there was evidence from which the DPA could have drawn a contrary conclusion, its decision was supported by substantial evidence.

(7) Loyd v. Georgia State Health Planning and Development Agency 310 S.E.2d 738 (Ga. App. 1983)

Several area residents brought an action seeking judicial review of the decision of the State Health Planning Review Board (SHPRD), an administrative appellate body, that they lacked standing to obtain administrative review by the SHPRD of the issuance by the SHPDA of a CON. The trial court ruled that the petition for judicial review was fatally defective because it failed to name the SHPRD as a party respondent, necessary because the SHPRD was the body which made the decision by which the petitioners were allegedly aggrieved.

The Court of Appeals held that although the SHPRD was an independent, separate entity from the SHPDA whose decisions superseded those of the SHPDA and were judicially reviewable at the request of the SHPDA, the SHPDA was the proper party respondent to the petition for judicial review, not the SHPRD, because the SHPRD was a quasi-judicial appellate body whose function was solely adjudicatory, having no stake in the outcome of the litigation nor duty or interest in defending its decision on appeal. Thus, the petition was not defective for failure to name the SHPRD as an indispensable party.

(8) Mercy Health Center v. State Health Facilities Council 360 N.W.2d 808 (Iowa 1985), rev'g No. 44313 (Iowa District Ct., Dubuque County, Jan. 4, 1984).

A hospital brought an action seeking judicial review of a state health facilities council (SHFC) decision denying its application for a CON to convert its acute care facility into an "elder care center." The project involved, among other things, establishment of a new SNF unit and renovation of space to residential apartment, mini-shopping mall, and other non-medical uses. The SHFC denied the application on the grounds of oversupply of SNF beds in the community and because its financing arrangement would result in cross-subsidization (i.e., revenues from health care services would contribute to non-health care services which could be provided by non-health care industries).

Under IOWA CODE ANN. §135.70 (1984-85 Cum. Ann. Pocket Part) a dissatisfied party must administratively appeal an SHFC decision to the Commissioner of Health (who may recommend SHFC reconsideration but not reverse the decision) before obtaining judicial review. In the course of upholding the SHFC decision, the Court held that this unusual administrative appeal provision was not intended to alter the scope of judicial review but merely to grant the Commissioner less authority than would ordinarily be the case.

b. State v. Areawide Agency Decision

(1) Cf. Page v. Capital Medical Center, Inc. 371 So.2d 1087 (Fla.Dist.Ct.App. 1979)

A hospital brought an action seeking judicial review of a state agency decision denying its application for a CON to construct a new hospital. The local areawide planning council made an advisory recommendation to the state agency that the application be approved. The trial court concluded that because under the state statute only the areawide council conducted investigations of CON applications, the state agency's function in issuing or denying CONs was purely ministerial (i.e., it rubber-stamped the areawide council decision). Apparently finding substantial evidence to support the areawide council decision, the trial court ordered a CON issued to the hospital. The District Court of Appeals reversed, holding that the state agency's decision to issue or deny CONs was not ministerial because the areawide agency's role was merely one of making an "advisory recommendation" to the state agency which had the final authority to issue or deny the CON.

V. PLANNING AGENCY REVIEW OF PROPOSED USES OF FEDERAL FUNDS (PUFF)

A. Medical Association of Alabama v. Schweiker, 554 F.Supp. 955 (M.D. Ala. 1983)

A physician and a state medical association brought an action challenging, among other things, the constitutionality under the First and Fifth Amendments of the HSA PUFF review provisions of NHPRDA (Public Health Service Act §1513(e); 42 U.S.C.A. §3001-2(e)) and regulations promulgated pursuant thereto. They also alleged that the defendant federal officials and federally-funded community health center had violated the PUFF review statute and regulations. The plaintiff physician was a private practitioner who alleged that he had suffered economic injury as a result of competition from the federally-funded community health center. The Court held that plaintiffs lacked standing on either of the foregoing claims because: (1) although plaintiffs satisfactorily alleged sufficient actual economic harm injury to satisfy the "injury in fact" element of Article III standing, their competitive injury did not suffice to establish standing because economic harm was not within the zone of interests protected by the First and Fifth Amendments; and (2) similarly, the language and legislative history of the HSA PUFF statutory provisions indicate that they were intended to provide for, among other things, a system of administrative review of proposed funding of community health centers in medically underserved areas, not to protect private physicians from the individual adverse consequences of competition. Private physicians do not fall within the zone of interests sought to be protected by the provisions and consequently they lack standing to challenge the manner in which the provisions are implemented.

standing because [illegible] of interests [illegible] (1) [illegible] and (2) [illegible] provisions [illegible] intended to provide [illegible] review of [illegible] health [illegible] patients [illegible] from the [illegible] private physicians do not fall within the zone of interests sought to be protected by the provisions and consequently they lack standing to challenge the manner in which the programs are implemented.

[illegible]

V. [illegible]

A. [illegible]

A physician and a state medical association brought an [illegible]

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